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JANUARY 1980
Volume 76, Number 1

THE OHIO Medical Journal

STATE



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Blue Cross Bill to Extend CON Into Physicians' Offices

Blue Cross has initiated a major piece of legislation which, if enacted, would extend Certificate of Need (CON) into the offices of Ohio physicians. Senate Bill 311 (Mahoney, D-Springfield) revises the definition of *medical equipment* subject to CON to include *any combination of pieces of equipment, regardless of location or ownership*, if the price of the combination of pieces exceeds \$150,000. Last session the OSMA was successful in obtaining a specific exemption from CON for physicians' offices.

SB 311 prohibits the granting of any CON that would increase the number of beds in any hospital, until the Ohio Department of Health certifies a new institution-specific state health plan. Each Ohio Health Systems Agency (HSA) is required within two years to develop a plan that identifies and names each facility with *excess* capacity or equipment and recommends "phasing out, consolidating, or otherwise eliminating such excess facilities, organizations, services, and equipment."

The legislation creates an Ohio Health System Redevelopment Authority that would levy a surcharge on each hospital of from 50c to \$1.00 per patient day for three years and from zero to \$1.00 per patient day thereafter. These surcharges would be credited to a Facilities Retirement Fund. The authority would be empowered to issue revenue bonds, bond anticipation notes, and other debt obligations. The proceeds of these debt issuances, which would become a lien on the Facilities Retirement Fund, would be used by the authority to purchase facilities and equipment deemed *excess* within the state health plan. As title holder the authority could convert, close, consolidate, or otherwise dispose of the facilities.

Senator John Mahoney, sponsor of the complex bill, has indicated a desire to work with the OSMA on the measure. No hearings have been scheduled on SB 311.

FEDERAL

Emergency Services

Legislation renewing the emergency medical services (EMS) program for three years passed both Houses of Congress with an easy resolution of House-Senate differences. EMS would receive \$40 million in each of the next three years, a radical departure from the Carter

Administration plans to phase out the program entirely. Included in the compromise is a provision establishing a HEW administrative unit to oversee the Sudden Infant Death Syndrome program (SIDS). Additional funds will go to the demonstration projects for burn injuries, poison treatment, and trauma, and to EMS research and training. The bill now goes to President Carter for his signature.

House Staff / NLRB Bill Defeated

By a 167 to 227 vote, the House of Representatives defeated HF 2222 on November 28th. This bill would have included medical house staff within the Labor Relations Act. HR 2222, which had bi-partisan support within the Education & Labor Committee, was not expected to encounter such firm House floor opposition.

Child Health Bill Passes House

On December 11th the House of Representatives passed HR 4962, the Child Health Assurance Act of 1979 (CHAP). As approved, the legislation makes an estimated additional 1,100,000 children and pregnant women eligible for Medicaid coverage. Also, it establishes a nationwide minimum-income standard for coverage of pregnant women and children, although any State has the option of covering persons with higher incomes.

HR 4962 broadens health care benefits provided to Medicaid children, increases the proportionate share of the costs of health assessments and out-patient treatment for Medicaid children, which is paid for by the federal government. The bill provides incentives for operation of more health assessment, outreach, and follow-up programs by the States. The bill provides that all types of eligible health care providers and agencies may serve as CHAP providers for Medicaid children and includes incentives to facilitate enrollment of Medicaid children with health care providers who will give primary and preventive care on a continuing basis (including HMOs). HR 4962 also provides for penalties (in the form of reduced matching of administrative costs) for States which do not meet minimum performance standards in their CHAP programs, and bonuses for those that perform exceptionally well.

The main stumbling block to passage of HR 4962 was the bill's coverage of family planning services to minors and the possible Medicaid funding of abortions. On December 11, the House by a 235 to 155 vote, approved an amendment to HR 4962 that would prohibit federal funds to be used to perform abortions "except

(Continued)

where the life of the mother would be endangered if the fetus were carried to term. . . ." The approved amendment also states that the prohibition, and any other Medicaid provision, "shall not be construed to require any State funds to be used to pay for any abortion."

In keeping with the present Congressional antiregulation mood, the House also approved an amendment to HR 4962 which prohibits a rule or regulation under the Child Health Assurance Act from becoming effective if both the House and Senate adopt a concurrent resolution of disapproval within 90 days after the rule's promulgation. Additionally, if one congressional chamber passes a resolution disapproving a regulation within 60 days of its promulgation, and the other chamber does not object within 30 days, the regulation does not become effective.

The December 11 House action portends difficult negotiations with the Senate over the Child Health Assurance Act. While the Senate has not acted on a bill, it is expected that less restrictive language on the abortion issue will be sought by the Senate chamber.

NHI Stalls Again

Despite concerted efforts by Sen. Russell Long (D-La.) to move a national health insurance (NHI) bill covering catastrophic medical expenses through his Senate Finance Committee, attempts to strike a compromise among committee members apparently have come up short.

To move the bill out of his committee, Long apparently will be forced to sweeten his catastrophic-only approach with concessions to liberal members in the form of expanded Medicaid benefits. Until some additional help for those with low incomes is added, it is unlikely that a consensus within the committee will emerge. And while some members would prefer to see any Medicaid expansion take the form of adding the Child Health Assurance Act (CHAP) to Long's catastrophic coverage bill, Long himself would prefer to stop short of CHAP's scope.

On the House side, there was no committee action on catastrophic NHI, making it even more unlikely that a Senate-approved bill will be taken up this year.

Reimbursement of Teaching Physicians

A five-member panel recently appeared before the health subcommittee of the House Commerce Committee. Two of the members were Dean Fairfield Goodale, M.D., Medical College of Georgia, representing the AMA; and Edward Brandt, vice-chancellor for Health Affairs, University of Texas System, representing the Association of

American Medical Colleges (AAMC).

The implementation of these proposed regulations, which would classify services provided by teaching physicians in hospitals as inpatient hospital services, and therefore reimbursable under Part A only, has been an active issue for several years. Both the AMA and AAMC statements often echoed expressed views on this subject — the need for delay or repeal of section 227.

The AMA stated: "The financial relationship between hospitals and their teaching programs and faculty vary because they respond to the unique characteristics of individual patients, hospitals, and teaching physicians. No single national solution will ever be satisfactory."

The AAMC recommended that an amendment be passed, which would delay implementation of the regulation until at least 180 days after the proposal could be published in the Federal Register, that a committee report reflect Congressional intent on this issue, and that the subcommittee monitor HEW's regulations on teaching physicians.

An Overview

During 1979, the Department of State and Federal Legislation had unparalleled success in presenting the opinions of organized medicine in the legislative arena. At the State Legislature the most significant success was the passage of SB 271 (Mahoney, D-Springfield). This bill will return over \$25 million to Ohio's physicians during the next year from the Stabilization Reserve Fund of the JUA. The Department was instrumental in securing this money for our members. Other successes included amending HB 80, the medical records bill that requires physician approval for release of employee medical records if the physician believes the information included in that employee record is harmful. The Department has stopped the proposed expansion of the responsibilities of physical therapists included in HB 210 and HB 211; continues to hold the Optometry Bill, HB 158 in committee, and stopped consideration of HB 162, a bill permitting chiropractors to utilize acupuncture. To date, HB 700/SB 231, bills that significantly expand the role of third-party payors in the review of medical activities, have not moved nor has SB 44, a bill that would impose state mandated third-party payor peer review systems.

Legislation supported by the OSMA is moving through the legislative process, for example, HB 470, a bill that permits money from liquor permits to be utilized in alcoholism education, has become law; HB 415, a bill permitting coroners to donate eyes to eye banks; HB 184, permitting the use of marijuana in cancer therapy; S.B. 209, permitting the expansion of convulsive therapy have all had hearings and moved successfully through part of the legislative process.

(Courtesy Department of State and Federal Legislation)

OSMA OFFICERS

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THOMAS W. MORGAN, M.D.
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Gallipolis 45631

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Elyria 44035

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Telephone: 614/228-6971

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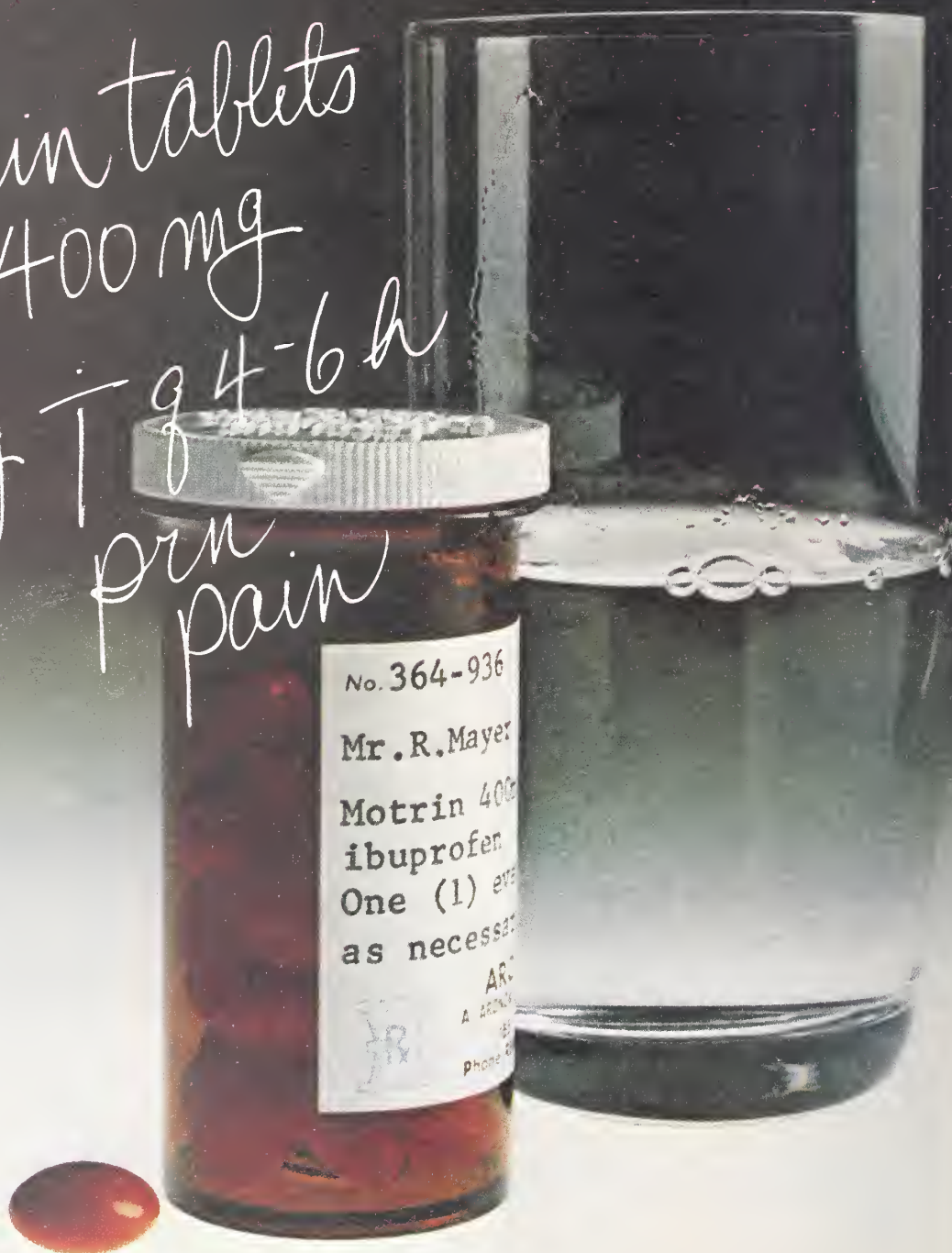
COVER: This month's cover won Best in Show in the 1979 Journal Photographic Exhibit. Robert L. Willard, M.D., Toledo, photographed this scene in Michigan. The title of the picture is "December." Dr. Willard used an Alpa 9D camera and agfachrome film. (Lens - 135mm, Aperture - 3.5, ASA - 50, and Speed 1/60.)

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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To the Editor.— I for one appreciate your including the article by Doctor Havener titled "Physician Attitudes Toward Caring for Older Patients," in the November 1979 Ohio State Medical Journal. Many times the dynamism of our lives is not shared with others because of a possible criticism of being unscientific. Yet in the clinical practice of medicine, attitudes are important in establishing rapport and the respect for our patients often has been lost.

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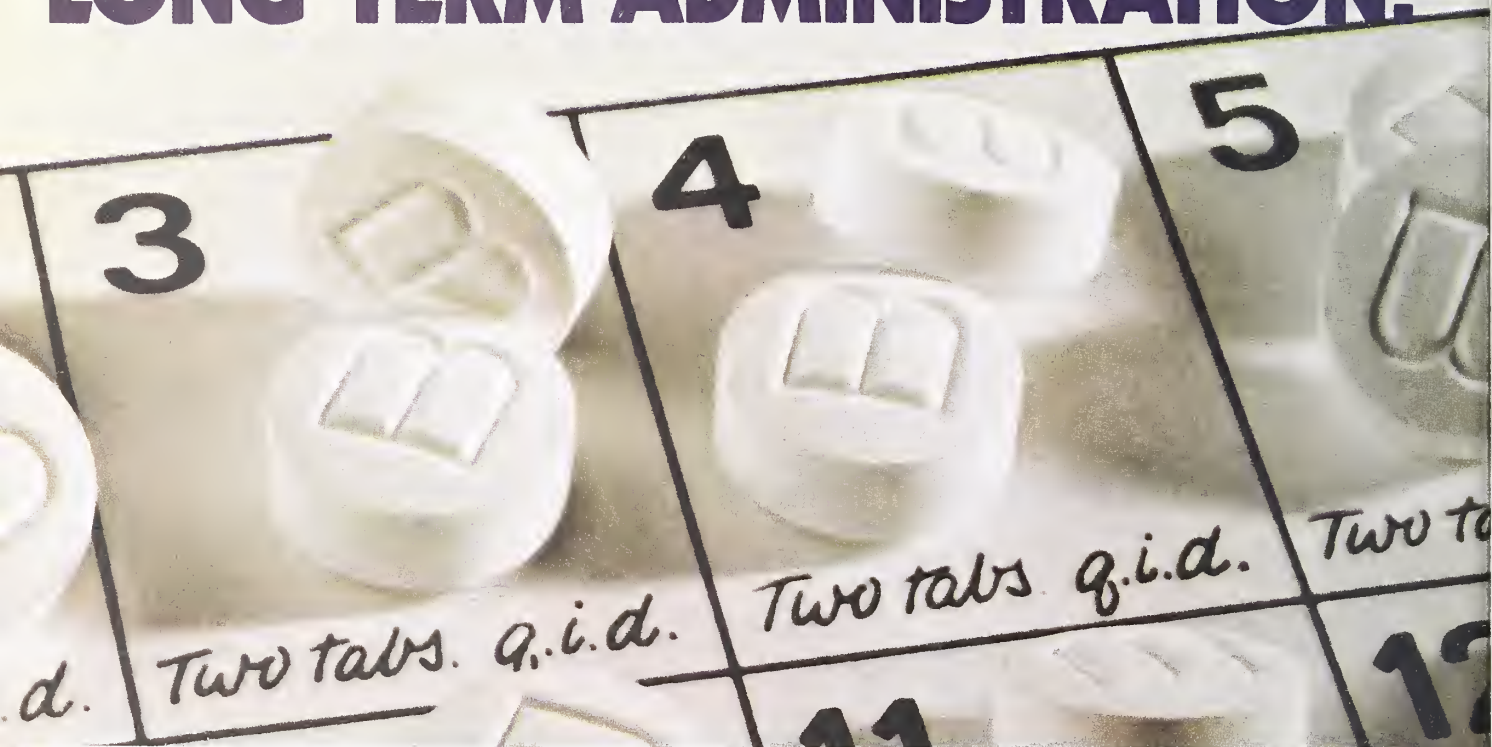
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Health Planning Amendments of 1979

The health planning and resource development authorities encompassed in P.L. 93-641 have been extended through 1982 with the enactment of The Health Planning and Resource Development Amendments of 1979 P.L. 96-79. Enactment of the new amendments will require major program changes.

Under the new amendments Certificate of Need (CON) requirements are extended to cover all diagnostic and therapeutic equipment costing \$150,000 or more, regardless of location, if the equipment is to be used for hospital inpatients. This new provision extends CON to include physicians' offices including the rental, purchase, or lease of covered equipment to be used primarily for hospital inpatients. States already requiring CON coverage of such equipment may continue to do so. States have until September 30, 1980 to opt for more stringent coverage. In addition, the State Health Planning and Development Agency (SHPDA) must be notified 30 days in advance of the intent to acquire major medical equipment meeting the \$150,000 threshold, even if the equipment will not be used for hospital inpatients. Failure to give the SHPDA 30 days notice of intent to contract for equipment will result in full CON review. The responsibility for determining if a CON will be required rests with the state agency.

States further are prohibited from requiring a CON for new inpatient services, major medical equipment, or major capital expenditures by a health maintenance organization (HMO), or group HMOs if the HMO has a minimum of 50,000 enrollees. All services provided must be accessible to all members and at least 75% of the patients expected to use the service must be prepaid enrollees.

Exemption from CON for capital expenditures also was granted to health care institutions for purposes of meeting fire or life-safety codes, to comply with state licensure standards and accreditation standards or for the acquisition of property or facilities. The key factor is that the SHPDA can withhold CON approval if the facilities or services are considered not needed or do not conform with the state health plan. The new amendments also mandate that health systems agencies (HSAs) can consider only matters related directly to CON requests when CON decisions are being made.

Changes in the National Guidelines on Health Planning state that Health Systems Plans (HSPs) must *take into account* the National Guidelines, replacing the language, *be consistent with*, in the original document. This should allow HSAs greater flexibility in determining

local need, instead of their previous mandate to follow federal planning guidelines.

The governing body requirements were amended to delete the category of *indirect providers*. Persons previously classified as *indirect providers* now will be considered *providers*. Also, an increase in the number of direct providers on HSA and SHCC governing bodies from one third ($\frac{1}{3}$) to one half ($\frac{1}{2}$) is required. These are to include a cross section of representatives of business, labor, and mental health agencies.

A new conflict of interest clause also was included which prohibits governing body members from voting on any matter *which such member has, (or, within the preceding 12 months before the vote) any substantial ownership, employment, medical staff, fiduciary, contractual, creditor, or consultative relationship*. Written disclosure of such relationship is required. Strictly interpreted, this provision may preclude providers from voting on regulatory reviews such as CON, 1122, and proposed use of federal funds. This provision currently is causing great debate because of its apparent ambiguities. It is expected that final implementing regulations will clarify federal intent.

P.L. 96-79 adds *pro-competition* as a new national health priority. This new sense of Congress emerged primarily because of the public's disenchantment with regulatory solutions to problems and an increased interest in deregulation. Legislative proposals manifesting pro-competitive ideas are seen in multiple choice options for employees, consideration of some tax law changes, and an HMO option for Medicare beneficiaries. New focus on restoring competition in the traditional system, (not only HMOs) is shown in HSAs being mandated to take into account an assessment of the competitive marketplace changes that will result from a CON proposal that is granted or denied.

Other provisions of the law require that health systems plans focus on health care equipment, institutional facilities, and services. It is further mandated that state health plans must be coordinated with plans developed by drug and alcohol abuse and mental health agencies within Ohio. The Governor is required to approve the State Health Plan (SHP) and only can disapprove the plans if they do not meet state health needs.

Another provision of P.L. 96-79 prohibits the use of federal funds for hiring a lobbyist. Strictly interpreted, this would not exempt HSA staff from lobbying activities if they were not hired to specifically provide that function.

An Approach to Cost Effectiveness

Darran N. Huggins, M.D.

Why should Ohio physicians become actively involved in their local Professional Standards Review Organization (PSRO)? One very important reason is that the local PSRO can be used as a powerful vehicle to dispel the myth that physicians are apathetic and ignorant about cost containment.

Ten years ago, Edward C. Andrews, Jr., M.D. President of the University of Vermont, stated: "The health care system is sick. Review data base and a list of serious problems emerge, several are potentially lethal: (1) lack of comprehensiveness; (2) lack of continuity; (3) high cost; (4) inadequate evaluation of professional performance; (5) inadequate maintenance of professional effectiveness; (6) irregular and unpredictable accessibility; (7) crisis orientation versus prevention; and (8) shortage and maldistribution of personnel and facilities."

Obviously the above problems overlap. High cost cannot be separated from other problems. During the last decade many of these problems have been studied, and numerous action plans have been proposed. However, *none* have solved the myriad of problems. In fact, many have contributed to, rather than helped solve, the problems.

According to Louise B. Russell in *The 1978 Budget Setting National Priorities*, there are several alternatives to regulating costs, including deductibles and coinsurance, Health Maintenance Organizations, and prospective reimbursement. The other types of controls directed toward quantities of resources used or services produced are Certificate of Need and the Professional Standards Review Organization. Our purpose is to concentrate on the effect PSRO can have on cost containment.

There are three patient care factors that are fundamental in determining the equity of care and the cost of care in hospital confinement cases. First, is hospitalization a medical necessity? Second, is the duration of hospital stay appropriate? Third, does the physician care meet the

recognized usual and customary standards of quality in the area?

To monitor these three fundamentals, Congress passed in 1972 the largest and most significant package of changes in the Medicare and Medicaid laws since their enactment. These alterations were part of a larger bundle of amendments to the Social Security Act—Public Law 92-603.

The alterations included Section 249, the Senator Bennett Amendment, which established Professional Standards Review Organizations (PSROs).

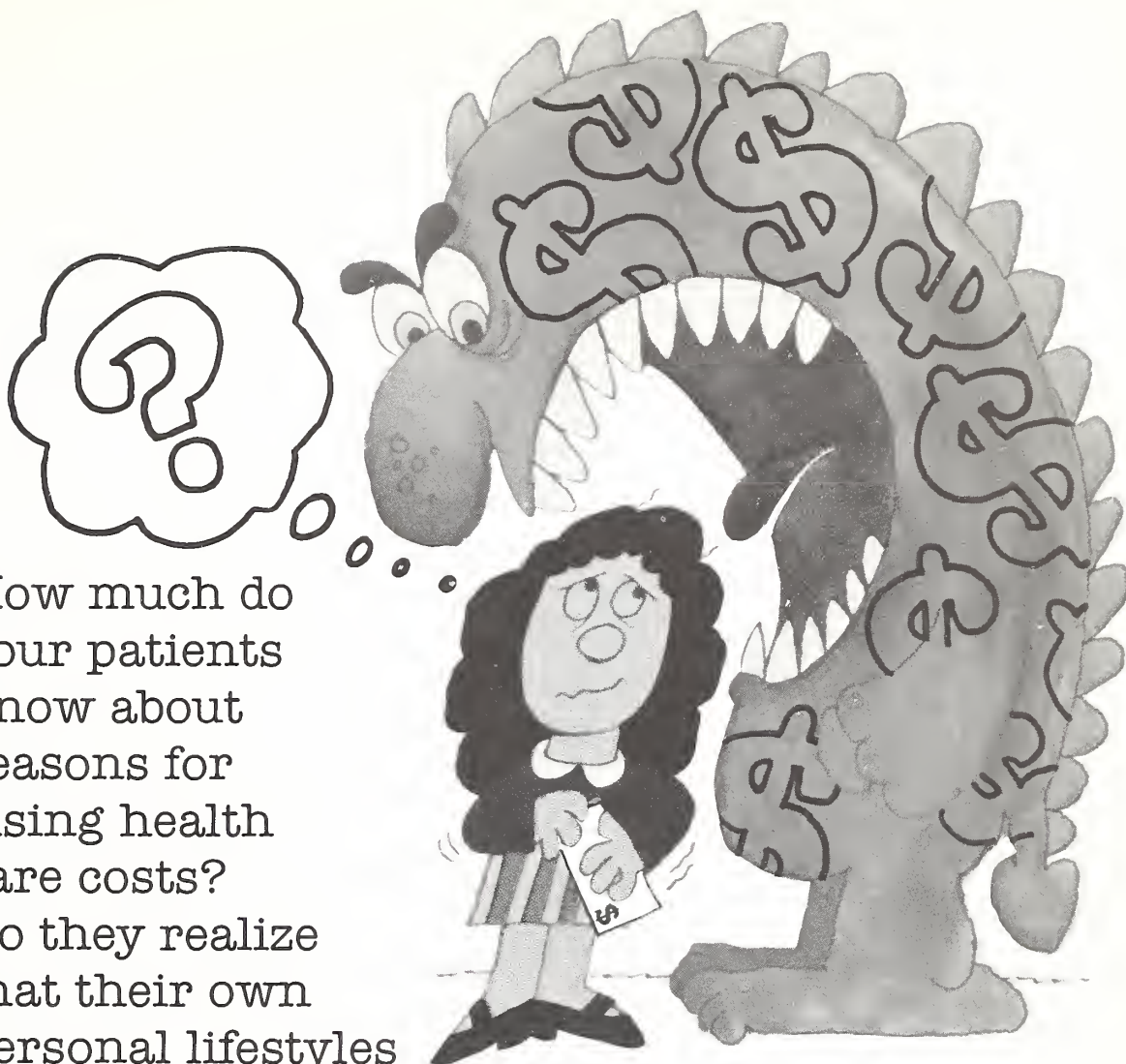
The purpose of the Bennett Amendment was to organize groups of physicians to monitor institutional care provided for Medicare and Medicaid patients.

However, sample systems were already operating during the late 1960s in Sacramento, California and in Salt Lake City, Utah. Length of stay monitoring for patient admission was implemented voluntarily by physicians in these states three years before Senator Bennett submitted the concept to Congress.

According to the law, each local PSRO is charged with formulating norms of acceptable diagnosis and treatment within its own area of jurisdiction.

Each PSRO is funded totally by the federal government. Currently, the cost of operating a PSRO is part of the total cost of operating the senior citizen's Medicare program. Each PSRO is incorporated separately according to the laws of the respective state, and each has a board of directors. Community and consumer participation is encouraged, but the law requires at least 51% of the board to be physicians (only MDs and DOs). It is a voluntary option of each physician to join. Once a PSRO is established, and its norms for care defined, they apply to all cases, physicians, and Medicare hospital services within the area. Medicare will pay only up to the norm established for that area.

In some areas PSRO physicians have found it difficult to find civic-minded individuals to serve on the



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How much do your patients know about reasons for rising health care costs? Do they realize that their own personal lifestyles may be contributing to this rise?

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PSRO board. As an alternative, some PSROs have established advisory committees to work closely with the board.

Since PSROs currently review only in-hospital care cases, they work closely with each hospital including its medical staff, administrator, and trustees. To avoid duplication of efforts, a PSRO can delegate to a cooperating hospital most or all of the scientific duties on a sub-contract basis.

Each PSRO has three major committees: Peer Review Committee, Health Care Standards Committee, and Medical Education Committee.

The Peer Review Committee develops, implements, and monitors the review system. The Standards Committee develops medical care screening criteria for review and evaluation studies. The Medical Education Committee determines individual and collective educational needs and tailors programs to meet those needs.

In addition, the Hospital Audit Committee makes evaluation studies with retrospective analyses of case records designed to document the quality of care provided in an institution. The committee selects the topic, defines the objectives of the study, and develops the criteria. It also determines whether physician performance variations from the criteria are justified. Its findings are submitted to the director of quality assurance, the administrator, and/or board of trustees.

It is important to note that the concurrent review process does not affect the physician's right to admit or discharge a patient, nor does a denial of medical certification mean that a patient must be discharged. It simply means that the federal government will not pay for care unless it is certified as medically necessary.

This federal policy may have a serious bearing on the Medicare patient's pocketbook. It may be medically necessary for a particular patient to have continuing care, but not medically necessary that the care be rendered in a general hospital. If the shift to a convalescent hospital or to a home care setting becomes necessary, Medicare funding would be reduced greatly.

Actually, the first intensive physician review of costs and standards of care by an organized committee of medical society members, for the benefit of insured patients, was initiated by the physicians of San Joaquin County in California 11 years before Medicare and Medicaid became law. The San Joaquin movement became known as the Foundation for Medical Care. Its goal was to conduct continuing review of insurance claims for standards of care and reasonableness of cost. The major new twist in the Foundation review concept was that claims were screened by practicing physicians, not exclusively insurance claims clerks. A physician reviewing physicians, and physicians knowing that peers were doing the reviewing, made a difference.

Another patient benefit created by the Foundation was that it enrolled physicians who agreed to the insurance plans payment to the physician as "fees-in-full" for covered services. The Foundation negotiated premium levels with all types of insurance carriers and underwriters. When illness or injury occurred, a patient would not have to face an unexpected out-of-pocket payment. It

is not necessary that all members of a medical society belong to the Foundation—only those who wish to, and who agree to abide by its rules and restrictions. Physician participation is high and membership ranges between 80% and 90% of the medical community in areas where Foundations exist. Currently there are more than 300 Foundations in existence.

In regard to professionals reviewing like professionals, Congress said: "PSRO is the means by which practicing physicians review the appropriateness and quality of service provided under Medicare and this review by physicians contains the greatest safeguards to fully protect the public interest." (Senate Report #92-1230-9/26/72, page 4.)

The action by PSROs provides a base of information by which medical services rendered and costs reimbursed can be judged as proper and equitable regardless of how funded.

We have come to a point when we find the *revolutionary* forces of compulsion (government) on a collision course with the *evolutionary* forces of the private health industry in the arena of professional standards review organizations. The way each participant handles its own role will contribute significantly to future patient care.

An insistence on the part of the government to move too rapidly, to force compliance too strongly, and to be insensitive to the needs of local communities, could result in not only a consolidation of resistance within the profession but a smothering blanket of conformity, a stereotype, a mediocrity which will elevate the bad and negate the good.

Every segment of the American health care system has some bearing on the other elements in the system. The patient, doctor, taxpayer, insuring unit, Congress, educators, and communicators all must be vitally and collectively involved and aware.

References available upon request.

Darran N. Huggins, M.D., Ashland, is a member of the OSMA Committee on Cost Effectiveness.

According to the Director of the National Center for Health Services Research (NCHSR), Gerald Rosenthal, Ph.D., drugs are the most widely used form of therapy in this country and account for a tenth of the nation's total health care bill.

Dr. Rosenthal explained that although strong evidence suggests that drugs are not always prescribed in the most efficient or effective ways, there have been few studies to assess techniques that could improve their use.

NCHSR recently has awarded 13 research grants to help evaluate the ways of improving drug-prescribing methods in the United States. Dr. Rosenthal said, "Results are expected to provide a basis for new policies and programs for government, private providers, and other organizations."

Recipients of OSMA Fifty-Year Awards

The following physicians have practiced medicine for 50 or more years. In honor of this achievement, the OSMA has presented each physician a plaque and a pin.

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Looking Back—Two Perspectives

John V. Gaeuman, M.D.
Len Paulozzi, M.D.

The following articles were submitted by John V. Gaeuman, M.D., and Len Paulozzi, M.D., graduates of Ohio State University College of Medicine.

The authors agreed to share with you their personal impressions of medical school, including serious and humorous experiences.

These articles are not intended to represent everyone's medical student experiences. However, after reading these stories, I encourage you to take a few minutes to reflect upon your medical school days.

Although there is a 21-year difference between years of graduation, it is interesting to note and compare the similarities in the doctors' experiences.—ED.

Reflections on Medical Education

Some 25 years ago, I was anticipating with trepidation my entrance into medical school. At the time, I had essentially no knowledge or understanding of such a career. I had never known anyone in the medical field and had only experienced minimal contact with physicians on a professional basis. I am still not totally certain why I made the eleventh hour adjustment of my undergraduate major to a premedical course. I had developed a genuine interest in physiology and biological science. While puzzling over what I could make of this education, the possibility of studying medicine first dawned on me, and I responded to its noble call.

The apprehension I felt beginning my first year of medical school was mingled with euphoria and elation. I viewed the study of medicine as something entirely different from anything I had ever experienced. It was as if I had been let inside to learn the wonders of a heretofore mysterious science, similar to being allowed the secrets of a great magician. As the first year progressed, my apprehension eased. I discovered that the academic

demands were not superhuman after all, and I found that if I applied myself with reasonable effort, achieving good grades was not difficult. Along with this increasing confidence and the beginnings of an identity with the medical profession, I began to develop some altruistic delusions concerning what I could accomplish as a physician.

The study of gross anatomy was a fitting introduction to my neophyte medical year, and for me appropriately reflected the concept of the classical medical student morbidly dissecting cadavers. There lingers the memory of leaving the anatomy lab and going directly to a meal of too-well-done roast beef at the AKK house where I boarded.

The first real feeling of becoming a confidant of the innersanctum of the great ivory tower of medicine occurred with the first clinical year. Now my eagerness and enthusiasm were sobered by initial evidences of apparent failure of the sciences of medicine. This seemed particularly acute while witnessing the plight of pediatric leukemia sufferers, when the state of the art was somewhat less successful. However, as a student, I did not realize how I was still insulated from the full sense of responsibility which would become totally mine after leaving the womb of training programs.

At the time I was in medical school, the emphasis was on specialization and research. The curriculum was more oriented to classic training. Community health and social problems were superficially considered in contrast to today's curriculum. The practical aspects of private practice management and medical economics were hardly mentioned. I believe most of my classmates, as well as myself, would have felt these subjects too mundane for our lofty clinical pursuits. After the first self-conscious, embarrassing patient contacts during the transition from basic science to clinical years, the concept of profound knowledge grew progressively through the completion of medical school, and indeed would continue through years of training as an intern and successive years of residency

and fellowship. To be sure, there were always bright senior house staff and faculty who could make at times a student feel ignorant and foolish, but these effects were temporary.

The medical student culture seemed aloof from the rest of society. The hours were long and at times rigorous, but we took pride in that. Indeed, as if to demonstrate our dedication and masochism, it was customary to work additional moonlight hours in externships at the "other hospitals" outside regular curricular demands. This admittedly had the added advantage of permitting the student to practice his/her new art (actually at this stage we practiced it as a science with little art) without faculty control, and at the time with economic compensation. The issue of the full white uniform was a milestone which paralleled the donning of the white coat at the beginning of the first year.

The symbolic trappings of the medical student received much attention. In addition to the white coat, there were other "tools of the trade." Miniaturization was in style. Small ophthalmoscopes, collapsible multipurpose neurologic hammers, and lightweight folding stethoscopes were the vogue. Pocket-sized reference texts matched tiny spiral or looseleaf class notebooks, requiring appropriate miniature writing and fostering the inevitable use of characteristic medical shorthand which continues to plague physicians' communication. This was abetted by a slow evolution of provincial favorites in addition to the old stand-bys such as **WDWN** and **PERRLA**. There is no question that this form was purposefully refined for a professional code as much as a time and space saver.

There was some good-humored awareness of these affectations. A popular film of the day depicting the education of an English medical student demonstrated the various technics of carrying the stethoscope, describing "biacromial," "postcervical," "axillary-inguinal," and "postgluteal" positions of the resting instrument.

In the years that have ensued, including military service, basic research, multiple residency and fellowship years, and then a somewhat remotely isolated "on-your-own" private practice, idealistic perspectives have tempered as I realized that medical science has not proved the salvation of mankind. The myth of omnipotence has dissolved. On the other hand, despite the frightening deluge of technology, I see an increased awareness of the practical and economic issues in medicine, and hopefully an increasing tolerance and appreciation of the contributions of other disciplines to the health of our society. I believe today's medical students have a better understanding of these issues than we did, for if their teachers do not put it there, their patients will. ☆☆☆

Dr. Gaeuman is an Assistant Professor in the Department of Preventive Medicine, Ohio State University College of Medicine. He was graduated from OSU in 1958.

Doctor in the House?

On the Cherbourg ferry heading for Southampton lounges a bearded, balding little man with his legs draped over the chair in front of him. His tasteless t-shirt advertises a restaurant in Mansfield, Ohio; and he sports shabby, red nylon shorts. His dress and his posture, both typically American, strongly contrast with that of the other tourists, who are almost entirely British. Since no English male over the age of four wears shorts off the squash courts, Her Majesty's subjects cannot help but glance discreetly and smile into their tea.

This curiosity, badly in need of a bath, is me, Len Paulozzi, rookie M.D. on vacation. I ignore the titters, since in my Jerry-Ford-of-a-life there have been many other embarrassing circumstances.

"If there is a doctor on board, please make himself known to the information desk," the loudspeaker requests.

Well, that's the first time I've actually heard that line . . . my God, they mean *me*!

Back four years. Ohio State College of Medicine EJ '75 entry photo. Bearded even then. Slightly less scalp showing, I think. Mandatory scruffy t-shirt of course. Judging from the silly grin on my face, I was quite pleased to be there, despite the prospect of three years of skullbusting work in Cowtown, U.S.A.

Over 200 of us converged on Columbus that hot-house July morning to take our places in medicine. If you look at the class snapshots you will see evidence of the temperature: tendrils of hair adhering to moist foreheads, wilting neckties, and shiny cheeks. Interestingly, in spite of the heat we all look starry-eyed, even triumphant. The total impression is reminiscent of a group of competitors in an athletic contest recently concluded, all of whom emerged with gold medals. Indeed, that was exactly what we were.

The Dean's welcoming speech was congratulatory and incorporated slides touting our "stats": GPAs, MCATs, number of applicants, number of interviews, etc. The attention was flattering, however, there was more to come. Within a few days we had completed medical histories, experienced our first physical exam at the hands of a colleague, inked our fingertips for the FBI, answered questionnaires on career objectives, and dulled our wits as well as #2 Ticonderogas on tests of cognitive functions, personality parameters, and spatial perception. No one objected to the spotlight, for we were in love with our new image as bright, young healers. We congratulated our comrades, once our rivals, and drank to our futures. The long abstinence of premedical life was finally, officially over. Little wonder we appeared intoxicated. The honeymoon phase of the romance of medicine had begun.

The immense amount of material to be absorbed in 15 months barely dented our enthusiasm, at least at first. Each took his own approach to the task at hand. If you saw school as a job with extremely low hourly wages, you called studying "getting some work done;"

if you were from Dartmouth or aspired to be, it was called "pounding;" and if anyone did it when you weren't, it was called "grinding."

Grinding always struck me as a singularly fitting metaphor for study, probably because I could almost hear our teeth working as we devoured knowledge. In fact, one might regard the preclinical months as the oral phase in our development, a time in which we ate with little discrimination and, on occasion, little appetite for the material, which was sometimes indigestible or without nutritional value. At regular hours we clustered at our carrels, hunkered down, and buried our noses in the printed trough, which was kept full by a modern, computerized feeding system. Life seemed streamlined to give us time to digest; wives, families, friends, even creditors pampered us.

Our comfortable study plan proved a valuable security blanket to cover a multitude of problems. When our neurotic conflicts rivaled Woody Allen's, crossing off completed readings proved marvelously comforting. When panic attacks threatened, there was always the clean, calming certainty of biochemistry. And when our sexual encounters proved as disappointing as Kahoutek and only slightly more frequent in appearance, there was always reproductive anatomy. At these times the spectre of the medical student as grind or cultural rodent scared some of us so effectively that every novel read, party attended, or lecture *not* attended took on added personal significance as proof of the inaccuracy of the stereotype.

Politically our shortcomings were understandable, if not forgivable. We were college freshmen at the start of the "Me Decade," freshmen for whom Watts and Kent State were dim memories and the draft a dying institution, never a real threat to our embryonic careers. Although the radicalism of the 1960s enabled many of us to disassemble frogs rather than M-1s, the pragmatism of the 1970s was a far stronger force in our lives. We embodied the political backlash of Bunker America as we beat a retreat to the grim professionalism which the 1960s had eschewed. The few remaining activists at OSU appeared to be anachronisms, out of touch with reality. A vocal minority did work in the Columbus Free Clinic or in the projects of AMSA's New Liberals, but there was only the sound of swallowing from the vast majority, myself included.

Nonetheless, the process of socialization was far from complete. As the weeks lengthened into months, as summer tans faded with our enthusiasm, and as we saw our youth succumbing to years of training, each of us had occasion to recall exactly why he or she wanted so badly to be a physician. The answers we provided our interviewers—a generous measure of "intellectual challenge" with a dash of "service orientation"—now seemed naive, if not inaccurate. A few discovered that their motivation, much like the journal citation provided by that cardiology fellow, did not really exist. For this minority the choice was quitting, now decidedly out of fashion, or else temporizing in hopes that motivation would grow with time

along with our debts. I personally tried both but found neither very comfortable. Eventually we all faced up to our doubts and rebuilt a rational if temporary framework where necessary to support our continuing careers, thus negotiating in both senses of the word our first "professional crisis."

One day we discovered, reaching blindly for the alarm in pitch blackness, that we were in the clinics. Let us pause for a moment to reflect upon the clinical clerk on day one, looking as cheerful and as intent as a maiden at her wedding about to discover she has just married the Marquis de Sade. I dressed for the occasion with my Man-From-Glad rags, my clipboard springing helpfully to hand, and my nifty blank file cards there in the breast pocket behind the six-inch ruler and the penlight imprinted with a pale blue caduceus. Under the spell of the seductive white coat, our glamorous self-image returned. Little did we realize how short-lived our innocence would be.

From round one we discovered that medicine was a cruel, demanding mistress. Our student status was apparently no deterrent to being abused as scutmongers, the time-honored function of clinical clerks. The point was not that the neophyte was "too good" for these tasks, but that they were counterproductive to a good education, the goal in theory of both the student and the school.

Similarly, we were encouraged to take on "as much responsibility as we could handle" in patient care but at the same time were not made to feel responsible for our own education, even though we had been students for 18 years and should have had some notion of how and when we learn best. I believe the common assumption was that if a student didn't have to do something, he wouldn't, whether it be attending a lecture or going through the review of systems.

The clerk also learned the preeminent value of detail in medicine, oftentimes to the extent of losing sight of the patient. In effect, he left the oral phase and entered the anal. In his pocket the model student carried a notebook containing the key facts of **The Principles of Internal Medicine** neatly handprinted on a microscopic scale and cross-indexed for quick reference. The serum esoterica levels and urine minutiae counts for the entire admission were microfilmed onto the three-by-five cards implanted in his palm. He recorded the entire review of systems in Bic fine-point and actually asked it before-hand.

What we found impossible to quantify as clinical clerks was what we were losing in terms of enthusiasm, independence, and sensitivity; the change was by and large beneath the threshold of awareness. What we *were* aware of was a vague, nonspecific anger radiating toward the medical profession originating in an as yet inarticulate sense of being forced to betray our ideals on occasion in order to accommodate the system.

Becoming a competent physician demands some personality changes, and admittedly some of these changes are beneficial. I am probably too close to this

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experience at present to judge it objectively.

Consequently, I do not yet know if I am better or worse for undergoing these rites of passage.

However, the fact remains that after attending Ohio State for three years I am somehow different. In particular, this came home to me for the first time on the ferry when the "doctor in the house" summons reached my ears. Anonymity was gone; I had been set apart from my fellow travelers and would forever be so marked. With this awesome realization floating in my head, I found my feet and ran for the door.

Amazingly, despite all the smudges and tatterings suffered at Ohio State, the excitement of day one, the sparkle in the eye, and the clean white coat were back again. Romantics, you see, never die.

Dr. Paulozzi entered a Master of Public Health program in Seattle this fall. He plans to do research and teach in the field of chronic disease epidemiology. He was graduated from OSU in 1979.

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JANUARY

REGIONAL SEMINAR IN PERINATAL MEDICINE #10: January 23; Cleveland Metropolitan General Hospital, Scott Auditorium; sponsor: Case Western Reserve University School of Medicine; co-sponsor: Cleveland Metropolitan General Hospital, Dept. of Ob/Gyn; 7 credit hours; fee: \$70, \$35 (residents and nurses); contact: M. J. Thomas, M.D., Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109, phone: 216/398-6000.

SURGICAL MANAGEMENT: HOW I DO IT. January 23, 24; Bunts Auditorium, Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: \$150, \$75 (students and physicians-in-training); contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone 216/444-5696.

CLINICAL ONCOLOGY UPDATE FOR PRIMARY CARE PHYSICIANS: January 25, 26; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine; 12 credit hours; fee: \$40 Wright State faculty, \$55 for others; contact: Arlene Polster, Wright State University, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

FEBRUARY

ADVANCES IN INFECTIOUS DISEASE AND ANTI-MICROBIAL DRUGS: February 6, 7; Bunts Auditorium. The Cleveland Clinic Foundation, Cleveland; Sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (residents). Contact: Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone 216/444-5696.

A WORKSHOP ON SOFT TISSUE SURGERY: February 8-10; Park Plaza Hotel; Sponsor: The Cleveland Clinic Educational Foundation; 15 credit hours; fee: \$200, \$100 (residents). Contact: Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

BLOOD BANKING: February 14, 15; Bunts Auditorium, Cleveland Clinic Foundation, Cleveland; Sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (residents and allied health). Contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, phone 216/444-5696.

MARCH

ADVANCES IN UROLOGY: March 6-7; Stouffers Inn On The Square, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106; Phone: 216/444-5696.

FIFTH ANNUAL OB/GYN SYMPOSIUM: March 6-8; Sonesta Beach Hotel & Tennis Club, Key Biscayne, Florida; sponsor: Wright State University School of Medicine, Dept. of Obstetrics and Gynecology; 15 credit hours; fee: \$225 Wright State faculty, \$250 for others; contact: Arlene Polster, Wright State University, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: March 8-15; Caribbean Islands, MTS DANAE of the Costa Line; sponsor: University of Cincinnati College of Medicine, Dept. of Otolaryngology; 24 credit hours; registration fee: \$300; contact: Ms. Robbie Cornelison, University of Cincinnati College of Medicine, Dept. of Otolaryngology, Room 6507, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4155.

A REFRESHER SEMINAR IN PEDIATRICS FOR PEDIATRICIANS AND FAMILY PHYSICIANS: March 12-13; Hollenden House Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$80, \$40 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

COLONOSCOPY—HOW, WHEN, WHY: March 14-15; Stouffers Inn On The Square; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$200, \$100 (physicians-in-training); contact:

Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NEPHROLOGY FOR THE NEPHROLOGIST:

March 20-21; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

EVALUATION OF THERAPY METHODS IN THE TREATMENT OF APHASIA:

March 24, 25, 26; Stouffers Downtown, Cincinnati; sponsor: University of Cincinnati Medical Center, Division of Audiology and Speech Pathology; 17 credit hours; fee: \$150, \$140 (non-physicians and allied health personnel); contact: Dorothy Air, Ph.D., University of Cincinnati Medical Center, 234 Goodman Street, Pav. A-122, Cincinnati 45267, phone: 513/872-4241.

NUTRITION: FACT OR FICTION IN MY DAILY PRACTICE: March 26; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine, Dept. of Family Practice; 8 credit hours; fee: \$40 Wright State Faculty, \$55 others; contact: Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

HEMATOLOGY UPDATE - 1980: March 26-27; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NUTRITIONAL SUPPORT: March 28-29; Stouffers Inn on The Square, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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PROCEEDINGS OF THE COUNCIL

November 10-11, 1979

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 10, and Sunday, November 11, 1979, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; A. Burton Payne, M.D., Ironton; William Dorner, Jr., M.D., Akron; John H. Ackerman, M.D., Columbus; Max D. Graves, M.D., Springfield; Craig Barclay, Esq., Columbus; Douglas Freeman, Columbus (PICO).

Those present from the OSMA staff Saturday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, David C. Torrens, Carol W. Mullinax, David W. Pennington, Eric Burkland.

Those present Sunday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; William Dorner, Jr., M.D., Akron.

Those present from the OSMA staff Sunday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Carol W. Mullinax, David W. Pennington, Eric Burkland.

Dr. Morgan introduced Herman I. Abromowitz, M.D., Dayton, newly elected Councilor of the Second District.

Dr. Morgan congratulated Dr. Thomas on his election as Speaker of the House of Delegates of the College of American Pathologists.

ADMINISTRATION DEPARTMENT

The minutes of the September 8-9 and October 28, 1979 meetings of the Council were *approved*.

The President announced that H. Thomas Ballen-

tine, Jr., M.D., member of the Board of Trustees, American Medical Association, will be present representing the AMA during the OSMA Annual Meeting May 10-14, 1980.

The Council voted to evaluate the balloting methods used in the OSMA House of Delegates and authorized the President to appoint an ad hoc committee to study the matter.

A draft resolution, providing for specialty society representation in the OSMA House of Delegates was presented by Dr. Ford. The Council referred the resolution to the OSMA Committee on Membership and Planning and requested that the committee prepare a "white paper" on the matter for report to the Council's January meeting.

The Council requested that more detailed analysis by committees be conducted in order that the Council may focus its attention on the broad, general concepts of the proposals presented to that body.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics, presented by Mrs. Wisse, indicated that current membership is 124 over last year's end figures.

Committee on Auditing and Appropriations

The minutes of the November 9, 1979 meeting of the Committee on Auditing and Appropriations were presented by Dr. Williams.

The Council voted that, in accordance with the recommendation of the committee, the Pension Committee action of October 25, 1979, with regard to lump sum settlements, *be approved*.

The Council *approved* endorsement of I.C. System, Inc., and will offer this collection service to members as a membership service, effective November 10, 1979.

The Council ratified the Director and Officers Insurance coverage for the forthcoming policy years as suggested by the committee.

A recommended grant of \$1,000 for Health & Human Affairs Conferences *was approved*.

A proposal of the committee for use of Master Charge and Visa to charge membership dues *was approved*.

The committee report, as a whole, *was approved*.

Treasurer's Report

Dr. Barr presented the Treasurer's report, which was received for information.

(Continued)



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Cincinnati, Ohio 45202
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DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Education

Mrs. Dodson presented the minutes of the September 20, 1979 Committee on Education meeting.

A recommendation that the Ohio Physicians' Recognition Award be discontinued was tabled.

The remainder of the report was accepted for information.

The minutes of the November 1, 1979 meeting were also considered.

DEPARTMENT OF GOVERNMENT RELATIONS

Health Planning Update

Mr. Pennington presented information on Public Law 96-79, in which Congress extended Health Planning for another three years and provided funding for the program.

Committee on Membership

Mr. Gillen presented the minutes of the Committee on Membership which met October 20-21, 1979.

The committee postponed consideration, until the January meeting of the Council, of the committee's recommendation that the Council prepare a resolution dealing with Report "B" of the AMA Council on Long Range Planning and Development.

The Council *approved* the committee's recommendation that the report of the OSMA Staff Task Force on Membership be approved for implementation.

A recommendation that a definite program be developed to encourage county medical societies to permit the OSMA to bill for dues in their behalf was adopted and the field service was asked to assist in this effort.

Also *approved* was a pilot comprehensive recruitment program and a program for greater involvement of medical students and residents.

The Council amended the minutes by substitution to ask the Membership Committee to bring to the Council suggestions for better communications and liaison with allied health professionals.

The question of specialty society representation in the House of Delegates was deferred for discussion in the Council planning session.

The report, as a whole, *was approved* as amended.

Committee on Cost Effectiveness

Mr. Gillen reported on the November 9, 1979 meeting of the Committee on Cost Effectiveness.

DEPARTMENT OF ORGANIZATION SERVICES

PICO Life Insurance Company of Ohio

Mr. Campbell and Douglas Freeman, Assistant Vice-President of PICO Life Insurance Company, presented information on two proposals involving membership services through the company—one being "Retired Lives Reserve" insurance and the other, establishment of a self-directed Keogh Plan. It was indicated that the Chairman

of the OSMA Committee on Membership Insurance Plan, Walter Daniel, M.D., had approved the presentation of the proposals to the Council.

The Council *approved* the plans, with the adoption of the following resolution:

WHEREAS, PICO Life Insurance Company, a subsidiary of Physicians Insurance Company of Ohio, is an insurance organization whose major purpose is to provide life insurance and related financial services to OSMA members; and

WHEREAS, OSMA recognizes the need to provide sound and effective financial and estate planning assistance to OSMA members; and

WHEREAS, OSMA and PICO Life Insurance Company have a common goal to provide plans suited to fulfilling this need;

THEREFORE BE IT RESOLVED, that the OSMA sponsor a plan of Retired Lives Reserve through PICO Life Insurance Company, for the purpose of providing group term insurance past retirement for OSMA members and members' professional corporations;

AND FURTHER BE IT RESOLVED, that the OSMA sponsor a self-directed Keogh plan, through PICO Life Insurance Company, initially trusted by Bank One Trust (formerly "First Trust," a subsidiary of City National Bank of Columbus).

Joint Underwriting Authority

Current JUA statistics were presented by Mr. Campbell.

Mr. Burkland discussed the progress of JUA legislation now in the Ohio House of Representatives.

DEPARTMENT OF HEALTH EDUCATION

Committee on Mental Health

The minutes of the September 23, 1979 meeting of the Committee on Mental Health were presented by the chairman, Max Graves, M.D., Springfield.

The Council *approved* the minutes, which included recommendations for support of Senate Bill 209, to change procedures for administering convulsive therapy to mentally ill patients and Senate Bill 160, for changes in appointments to community mental health boards (648 boards) to restore requirements for physician participation on the Boards.

The Council discussed the Impaired Physicians Program and *approved* a recommendation for the creation of an Impaired Physician Subcommittee of the Committee on Mental Health.

Ohio Communicable Disease Reporting Project

Mr. Clinger presented a progress report on the Ohio Communicable Disease Reporting Project.

Ohio State Medical Association-Ohio Nurses Association Liaison Committee

Mr. Clinger reported on a meeting with representatives of the Ohio Nurses Association held October 24,

1979. He indicated that a session on physician-nurse relationship will be held May 12, 1980, during the OSMA Annual Meeting.

The Council agreed that articles appear side by side in both *Ohio State Medical Journal* and *Ohio Nurses Review* with regard to physician-nurse relationships, one article presenting the nurse's viewpoint and the other, the physician's opinions.

Committee on Health Manpower

The Council considered a request to endorse a transport service to the neonatal intensive care unit at Children's Hospital in Columbus, and referred it to the Committee on Health Manpower for more information.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Federal Legislation

Mr. Mulgrew announced that HR 2626, President Carter's Cost Containment legislation, was scheduled for Congressional action in the U.S. House of Representatives, November 15. He felt that an opportunity to present the "Gephardt substitute," supported by medicine is about "50-50."

Mr. Mulgrew reported on his visits to the Washington offices of the College of American Pathologists, American Society of Internal Medicine and the American College of Surgeons.

A letter from President Morgan and Dr. Ford, Chairman of the State Legislative Committee, to presidents of county medical societies asking specific efforts in support of medicine's legislative program was endorsed and supported by the Council.

State Legislation

The Council discussed H.B. 753, Hospital Licensure legislation, regarding hospitals in Ohio to meet JCAH standards and referred it to the Committee on State Legislation.

Dr. Ford, chairman of the Committee on State Legislation, asked for more liaison with state specialty societies and has communicated with those organizations.

COMMUNICATIONS DEPARTMENT

Ms. Doll reported on the success of the OSMA poster program on cost effectiveness and programs involving the electronic media.

Ms. Mullinax reported on the *Synergy* promotion campaign.

The Council endorsed policy of recognizing the 75th anniversary issue of *The Journal* in August, 1980.

Ad Hoc Committee on Letters to the Editor and Editorial Policy

Dr. Diller reported on the November 9, 1979 meeting of the Ad Hoc Committee on Letters to the Editor and Editorial Policy.

The committee recommended that a "Letters to the Editor" column be established in *The Ohio State Medical Journal*.

Guidelines were proposed for the review of letters submitted and it was requested that a permanent "editorial committee" of the Council be established to implement the guidelines.

The Council accepted a recommendation dealing with "Letters to the Editor," namely— items one through six, with the deletion of item 5, on page one and two and accepted items three, four, and five on page three.

The final sentence of the minutes was adopted.

Items one, two, and six, on pages 2 and 3, dealing with whether the scientific section be phased out, that The Journal concentrate its efforts on socioeconomic articles and with the change of the name of The Journal, were re-referred to the committee.

The report was accepted as amended.

LEGAL COUNSEL REPORT

Mr. Craig Barclay, Esq., presented the legal counsel report.

DIRECTOR OF HEALTH

Dr. Ackerman reported to the Council as Ohio Director of Health. He announced the receipt of a \$200,000 grant for a program on diabetes.

AUXILIARY

A letter from Mrs. Monica Kaye, president of the OSMA Auxiliary requesting approval of several actions was discussed by the Council and all items were *approved*.

ATTEST: Hart F. Page, CAE
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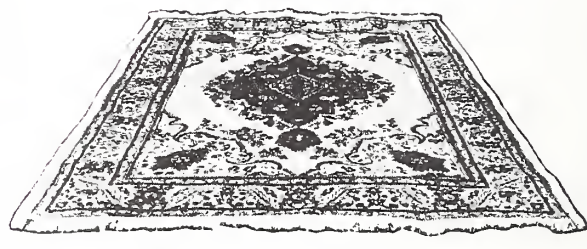
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Physicians and Nurses: Two Kinds of Practitioners

Gertrude Torres, R.N., Ed.D.

Editor's Note. — *This article by Dean Torres, a member of the Joint Conference Committee on Common Issues of the OSMA and the Ohio Nurses Association (ONA), expresses her Association's opinion and does not reflect the policy of the OSMA. The need for single direction in the medical care of a patient demands that the physician exercise the decision-making role in patient care.*—R.L.M.

Conflict persists among both physicians and nurses as to the meaning of the term "practitioner." It is essential that both the medical and nursing professions face the issues surrounding this conflict. They must collaborate in an effort to effect an increased understanding of the different roles and functions for providing quality health care to the consumer.

THE PRESENT POSITION of the professional nursing organization in relation to its determined role within the health care system is:

1. Nursing does not want or have the legal authority to practice medicine.
2. The major emphasis is on providing holistic nursing care to all age groups within a variety of environments to the maximum of their human health potential.
3. Nurses' education does not prepare them to assume the role of physicians.
4. Consistent with its training and knowledge, the nursing profession works collaboratively with physicians to provide health care services to the consumer.

Conflict persists among physicians and nurses as to the meaning of the term "practitioner." The word is used loosely and sometimes inappropriately, creating

social, political, and economic barriers as well as strange relationships among the health professionals. All too often, nurses' and physicians' writing is confined to their own professional journals. This results in confusion among leaders as to various policy positions of these two professions. This invitation for a leader in the nursing profession to prepare an article for publication in a medical journal must be viewed as encouraging.

The Nurse Practitioner

The term practitioner, according to Webster, means "one engaged in the practice of a profession." This should be viewed as the "uncontaminated" use of the term. Thus, any registered nurse is a practitioner of nursing. Explicit meaning of the use of "practitioner" was given to medicine and nursing in 1965 by Dr. Henry Silva, Professor of Pediatrics at the University of Colorado, when he inaugurated the concept of the pediatric nurse practitioner. This individual would assume much of the well-baby care and management of simple pediatric illness previously performed by pediatricians only. Confusion soon followed, especially as to the meaning implicit in management of simple (pediatric) illness in terms of who decides what cases the (nurse) practitioner manages. The answer is simple — it is the physician, as noted in current/existing legislation.

The role and function of nurse practitioners, legally as registered nurses, are *dictated* by law. According to the Revised Code of Ohio:¹

Practice of professional nursing means the performance for compensation of acts requiring substantial judgment and specialized skills based on knowledge and application of scientific principles learned in an approved

Dr. Torres, President of the Ohio Nurses Association, and Dean and Professor, School of Nursing, Wright State University.

Submitted June 20, 1979.

school of professional nursing. Acts of medical diagnosis or prescription of medical, therapeutic, or corrective medical measures by a nurse are prohibited.

This statement *clearly* prohibits nurses from diagnosing or treating disease. Registered nurses are engaged in such practices *only* when a licensed physician deems it appropriate. Practicing nurses have been long involved in executing medical regimens as prescribed by a licensed physician. This legal restriction in the practice of nursing is nationwide.

The Ohio Nurses Association recently prepared a statement on the role of the nurse practitioner. This statement supports nursing's role in the area of primary health care. It is defined as care to the consumers during their initial contact with the health care system and/or the continued care of the individual as an ambulatory consumer. Inherent in their practice is the identification, management, and/or referral of health problems, and the maintenance of the consumer's health by means of preventive and promotive health care actions. Emphasis is placed on the continuity of health care which transcends all settings and views the client or consumer from a holistic and health-oriented point of view *and* is complementary to the roles of other health care professionals. The physician is recognized as the expert in the medical aspects of health care, the nurse as the expert in nursing aspects of health care. When overlapping of functions occurs, a mutually agreed-upon framework must be developed.² Again, nursing has recognized its appropriate legal role and the need to function collaboratively with the physician.

Consistent with this statement is the notion that registered nurses are independently licensed professional practitioners who are qualified and can offer services to the consumer without the presence and/or prescription of a physician. For example, nurturing, health teaching, caring, assisting patients/clients of health care in their activities of daily living, and helping patients and families face death with dignity are the domain of the registered nurse. The physician needs to recognize that nurses do have independent functions and that physicians and nurses together can optimize the health potential of the patient/client. Were this not true, the nurse would need no license to practice and would not be directly accountable to the patient/client for care rendered.

The Role and Function of Registered Nurses

The issue is not, and never has been, whether nurses should practice medicine (that is illegal), but rather, what is the role and function of registered nurses within the health care system? The problem of overlapping functions between medicine and nursing has increasingly caused much concern and confusion. The American Academy of Pediatrics originally supported pediatric nurse practitioners in their efforts to extend the physician's practice, but recently withdrew this support fearing too much independent action and competition by nurse practitioners regarding patients. This has

caused "battle lines" to be drawn both nationally and on the local level. Unfortunately, this demarcation and friction further impedes the ability of organized nursing and medicine to collaborate on attaining improved consumer health care. This requires cooperative action in clarifying the roles and functions of the respective practitioners.

As stated earlier, nursing does not want to practice medicine which traditionally has focused on the cure and treatment of disease. More and more, the nursing profession is moving toward a broader range of functions that it can offer to the consumer of health care. These functions expand nursing's traditional role in health maintenance, health promotion, and preventive care. They include assessing the consumer's health habits such as nutrition and weight control, exercise, sleep, relief from stress, protection from occupational hazards, and providing necessary health education. Health histories taken by nurse practitioners focus on such assessment data and, when appropriate, result in referrals to physicians for medical care. Nurse practitioners who function outside of the hospital setting tend to focus on health-oriented rather than disease-oriented or illness care. Within nursing, this is seen as a necessary trend since the health care needs of society will continue to be met in the nonhospital, ambulatory care setting. Thus, it could be said that for the most part physicians focus on illness care — diagnosing and treating disease — while nurses focus on health care — promotion of health habits conducive to maximizing an individual's health potential to remain or become well. Nurses are concerned with the individual's response to actual or potential health problems.

The Nurse Practice Act

The training of registered nurses within the State of Ohio is predicated upon the fact that they are accountable to the consumer for all nursing practice. To this end, the House of Delegates of the Ohio Nurses Association adopted concepts of change to the Nurse Practice Act in 1976. They identified the scope of the registered nurses as:

Concept 1. Scope of Registered Nursing. The scope of the practice of registered nursing means the exercise of judgment in the application of scientific knowledge with the focus of providing care to and coordinating care for individuals, families, and communities, both ill and well, with the goal of attaining, maintaining, and restoring optimal health. Registered nurses are accountable to the consumer for all nursing practice.

Encompassed within this scope are the following competencies:³

1. Assess the health status and potentials of individuals and groups.
2. Identify deviations from optimal health status of individuals and groups, and make appropriate referrals if indicated.
3. Assist individuals and groups in the establish-

ment of realistic health goals.

4. Plan and implement the nursing plan of care by providing direct or supportive care, health teaching, and health guidance and counseling as needed to attain health goals.

5. Evaluate responses of the individuals and groups to health care plans and make appropriate changes therein, independently and/or in consultation with nurse colleagues and/or other members of the health care team.

6. Implement the medical plan of care prescribed by a licensed physician or dentist if the patients are unable to execute such a plan.

7. Institute emergency procedures to sustain life.

8. Cooperate and collaborate with other professionals in the health care team.

9. Perform those additional services requiring education and training which are recognized by the nursing profession as properly performed by nurses licensed under this Act.

These competencies are clearly within the domain of nursing practice and should not be construed by nurses or physicians as roles and functions embracing the practice of medicine. Nurse practitioners engage in nursing, complementing the physician's role. Nurse practitioners base their practice on nursing knowledge which differs distinctly from that of the medical profession. Although nursing actions include implementation of physician's therapeutic regimen, by far, most of these actions consist of developing a therapeutic relationship with clients and applying nursing technics and procedures. This applies to the needs of those acutely ill, chronically ill, or desiring to maintain a level of health or attain a higher level of health.

Admittedly, some nurse practitioners, with physician approval and/or encouragement, practice what might be construed as medicine. They have the support of physi-

cians in most instances, however, their professional colleagues take exception to such behavior.

The health care delivery system is undergoing tremendous change with increasing emphasis on alternatives to hospitalization and illness care. Physicians and nurse practitioners must acknowledge the interdependence of their practice to provide health care services to the public. They must work together to clarify their changing roles and functions.

Conclusion

The nursing profession is undergoing changes in an effort to meet the nursing needs of our society more adequately. Such changes are needed in the context of the social and economic forces affecting every health professional. Today, more than ever, roles and functions must be clearly delineated to avoid continuing confusion. This is possible only if both professions work together recognizing that each has something unique to offer the consumer. Nurses want the opportunity to improve health care through joint efforts with physicians. This can be done; it must be done. In 1965 the Ohio Commission on Nursing stated:

Issues related to scope of practice must be faced objectively by nursing and medicine in order to promote the best possible utilization of the talents of nurses and physicians.

So let us work together.

References

1. Revised Code of Ohio, Section 4723.06, *Practice of Professional Nursing Defined*.
2. Ohio Nurses Association, *Role of Nurse Practitioners* (1978).
3. Ohio Nurses Association House of Delegates, *Concepts of Change to Nurse Practice Act* (June, 1976).
4. Ohio Commission on Nursing. A study of Nursing Needs and Resources: Report of the Ohio Commission on Nursing, Columbus, Ohio: Division of Nursing, Ohio Dept. of Health, 1975 ☆☆☆



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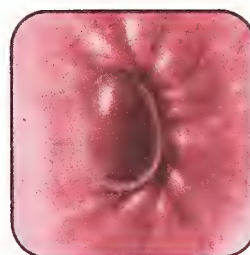
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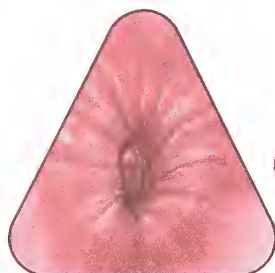
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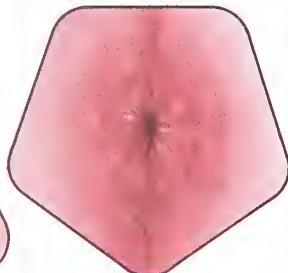
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Physician-Nurse Relationship From the Physician Viewpoint

William E. Sovik, M.D.

EDITOR'S NOTE: *The views expressed in this article are solely those of the author, and do not represent necessarily the policy of the Ohio State Medical Association. R.L.M.*

GRADUATION DAYS for my family are recalled with pleasure when I consider the nurse-physician relationship from a physician's viewpoint. When my wife in the 1930s and our two daughters in the 1970s received their caps and degrees in nursing, they recited the Florence Nightingale Pledge. When I graduated from medical school I recited the Oath of Hippocrates.

As all of us believed then—and believe now—our oaths obligated us to *take care of patients to the best of our ability*. A new family bond was established after receiving our degrees. We now *care* more for each other and we *care* more for our patients. Our family has a natural, warm, physician-nurse relationship.

Looking beyond my family, I discovered that nearly every statement of the National Joint Practice Commission since 1972 is introduced by “to promote collaborating efforts between medicine and nursing for the improvement of patient *care*,” or “providing *quality health care* of the American people.”¹

I cannot overemphasize the word *care*. It is *caring* by both physician and nurse *for the patient* which is the only reason for our professional existence.

There are three other “Cs” in addition to caring. *Communication, cooperation, and compassion* among physicians and nurses are vital to both professions.

Relative to the latter, the emerging role of the nurse practitioner has caused considerable confusion among physicians. By definition there should be no problem, since the nursing profession states that the nurse is to practice

nursing, not medicine—and the medical profession states that the physician is to practice medicine, not nursing.

The delineation between our professions seems less clear when one reads the following excerpt from the “Role of Nurse Practitioners” published in 1978 by the Ohio Nurses Association:

“The practice of Nurse Practitioners, as that of other registered nurses, overlaps in some areas with the practice of physicians.”

It is this *overlap* which concerns me and my physician colleagues. I believe strongly in the statement, “One unvarying aspect of a doctor-patient relationship is decision making. Physicians are prepared by education to make decisions and judgments affecting the lives of patients. Medicine is an art and inexact science requiring the development of judgment and decision-making skills.”²

The same ONA statement defines the Nurse Practitioner as: “An R.N. who is a primary health care provider directly responsible and accountable to the consumer.”³ This definition certainly emphasizes the independent practice concept which, in my opinion, contributes significantly to the overlap with physicians. Isn't the nurse responsible to the physician, also?

Let me be direct. A nurse, while capable of following procedures in managing common illnesses, does not have the depth of education of the physician, and therefore will be less capable of recognizing uncommon diseases or atypical manifestations of common diseases. Therefore, if the nurse practitioner is to contract with the consumer for primary care health services, there should be disclosure to the consumer that such services are limited in scope.

Dr. Sovik, Poland, Ohio, Chairman of the Committee on Health Manpower, Ohio State Medical Association; Member, Joint Committee on Common Issues and Concerns of ONA and OSMA; and Member, Ohio Council on Nursing Needs and Resources, representing Region E.

Please keep in mind that the nurse by law cannot diagnose or prescribe.

When a patient presents himself to the physician, the physician takes a history because he *cares*. He looks and he listens—critically and in depth with patience and compassion.

The patient permits the physician to do a physical examination on a body that is sacred. With this privilege the physician has definite responsibilities, which only the physician should be permitted to delegate.

A health professional other than a physician may take the history and/or do a physical. Does this person have the equivalent education and skills? Can he or she note, convey, and interpret eye responses, minor inflections of voice, and hand and body reactions? Can the professional then relay these responses accurately to the physician?

Can he or she elicit from the patient "what the patient wants to tell, what he doesn't want to tell, and what he cannot tell,"⁴ unless interrogated gently, calmly, and thoroughly by the experienced physician? I doubt it!

Let me return again to the keynote of this presentation; that of communication, cooperation, and compassion among physicians and nurses to insure proper *care* of the patient. For example, a clinical nurse conveys her impressions to the physician about a hospitalized patient with an acute bleeding, duodenal ulcer. The physician had previously made his diagnosis and prescribed the necessary regime. Through constant observation of the patient, the nurse notices a change in the patient's condition. The nurse recommends that the treatment should be altered. The nurse and physician discuss this recommendation—keeping in mind that the nurse sees the hospitalized patient for longer periods than does the physician. Once a decision is made, both physician and nurse then cooperate in explaining a new treatment modality and correcting, if necessary, even the underlying etiology of stress. This is care!

In summary, I would like to make the following points:

1. The physician-nurse relationship, as in a family relationship, should be strengthened with four big Cs—Communication, Cooperation, Compassion, and *Caring*.

2. The practice of medicine, including diagnosing and prescribing, is legal for only those holding a medical degree.

3. The physician should exercise the decision-making role in patient care.

4. "The growing influence of non-MDs in Health Care is helpful if we lead with reasoned guidance,"⁵ into the future.

5. *Caring* by the physician and nurse for the patient, who is made to the image and likeness of God, is our primary joint concern.

Acknowledgement: The author is grateful to the following individuals for their invaluable assistance in preparing this paper: William M. Wells, M.D., Newark, Cochairman, Joint Committee on Common Issues and Concerns of ONA and OSMA, and Member, OSMA Committee on Health Manpower; Robert D. Gillette, M.D., Toledo, Member, OSMA Committee on Health Manpower; and Robert D. Clinger, Associate Executive Director, Ohio State Medical Association.

References

1. Statements published by NJPC, September 1977.
2. Effective use of physician services. Diller. Ohio State Med J, Volume 75, No. 5, May 1979, page 295.
3. Role of Nurse practitioners. Ohio Nurses Association, 1978.
4. What are physicians for? Carson RA. JAMA, Volume 238, No. 10, September 5, 1977, pages 1029-1031.
5. Good medical care is caring. Barclay WR. JAMA, Volume 240, No. 22, November 24, 1978, page 2471. ☆☆☆

Warts: The Bane of Our Existence ---Even in Children

Leon Goldman, M.D.

The presence of warts in children suggests examination of the entire family to detect early, small lesions. Recent studies indicate specific antigens for different types of warts. If possible, initial therapy for children should be mild and colorful. Efforts should be made to prevent spread of the lesions. More intensive treatments may be conducted later.

IT USED TO BE THOUGHT that even though warts were difficult to treat in adults, they still were much easier to treat in children. Warts were so common in children that an old fallacy was that perhaps every child should get them and avoid having them when they grew up. Finally, the spread of warts as a contagious infection in the family group was not appreciated.

Today, the incidence of warts in children is increasing. Warts continue to offer treatment problems for the child and for the other patients in the family group. Moreover, your favorite treatment for warts only works for you; it never works for anyone else.

The Clinical Aspects

Extensive developments of the immunobiology of warts have occurred recently. Do these new develop-

ments offer any therapeutic help in the management of warts?

The following classes of human papovavirus (HPV) are recognized in man: (1) the common wart; (2) the plantar wart; (3) the flat wart; (4) the condylomata acuminata; and (5) the epidermodysplasia verruciformis.

The characteristics of type 4 (HPV-4), the uncommon epidermodysplasia verruciformis are:

1. It is a genodermatosis.
2. Clinically these are flat warts, reddish in character, chiefly on the backs of the hands, scattered on the shoulders. Some are psoriasiform and depigmented spots also may be present.
3. Malignancy develops in 30% or more of them.

In general practice, the molluscum contagiosum lesions are the ones most often confused with the wart. The small dimple in the center, the characteristic little pearl on curettement, and cytology showing the characteristic bodies, will be helpful in the differential diagnosis, which is very important. With the current epidemic of venereal warts, molluscum contagiosum is also spreading as a sexually transmitted disorder. Venereal warts sometimes reach tremendous size, especially in the adult. Although the digital, plantar, and facial warts are more common in children, with the current epidemic of venereal warts, condylomata acuminata also may occur in children in the family group, even in infants. These condylomata acuminata, through contact with an infected adult, may develop about the perianal area, lips, and even in the mouth. It often is not possible to determine if these are acquired through sexual abuse of the child or by common family contact. However, a history concerning sexual abuse should be taken.

The differential diagnosis of warts on the feet often is associated with corns. This confusion occurs today even in young children because of early use of improperly fitted shoes. Debridement, showing the typical plug of the wart as opposed to the single eye of the corn, the so-called "hen's eye," often helps. Occasionally, there is a tiny milium wart, a plantar white spot, smooth, firm, and developing satellite lesions without callosities.

Presented as a special lecture at the Children's Hospital, San Diego, California, April 13, 1979.

Dr. Goldman, Cincinnati, Active Staff, Children's, Holmes, Jewish, and University Hospitals, Courtesy Staff, Bethesda and Christ Hospitals; and Professor Emeritus, Dermatology and Director, Laser Laboratory, University of Cincinnati College of Medicine.

Submitted August 13, 1979.

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Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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The other difficulty in the differential diagnosis concerns whether the wart heals after treatment. A solid white spot remaining the same size and having sharp margins around the edge usually indicates a healed scarred wart; of course, a hypertrophic hard scar also must be considered. The development of a vegetative border with a clear zone in the center is characteristic of the "cauliflower" recurrence of warts after treatment with cantharidin. This therapy is used frequently by pediatricians.

As additional aid in the differential diagnosis of warts, the superficial portion of the warts may be peeled off. Then the skin is cleared with alcohol or oil and the spot examined with a magnifier or a skin microscope. The microscope may be monocular or the long-lens, stereobinocular microscope, which is preferred more. The plugs characteristic of the epidermal proliferation of the wart can be seen. Sometimes the plastic diascope or a glass slide placed on the surface also will show the multiple plugs.

The small hemorrhagic spots found in a wart are not the so-called "wart roots." They are simply the result of repeated trauma with bits of blood remaining in the superficial tissue for long periods of time. This is found especially over the heel following sports activities. Bleeding under the skin without, or often after, destructive wart therapy even simulates a melanoma.

There is an association between polyps of the larynx and warts in children. It is hoped that the immunologic studies will aid in the prevention of these recurring laryngeal lesions.

Immunologic Aspects

Current immunologic studies suggest that each type of wart has a specific antigen. As studies continue, more types of these wart viruses may be identified and their immunologic properties determined.

Immunodiffusion and complement-fixation antibodies are the technics used to measure wart antibodies. In such studies, medical students with no history of warts were used as controls, assuming they could furnish adequate physical and family histories. Of these controls, 50% have high titers of antibodies to warts. Does this indicate a latent viral infection in man? Under various types of immunosuppressive therapy, this latent infection becomes aggressive and lesions spread over the body. Similar immunologic studies in children are lacking today. In adults, the antibodies in chronic virus infections usually are IgM. A cross-reactivity between the warts of the mucous membrane and the warts on the skin exists. When there is regression of warts in adults there is usually a heightened response of the cellular mediated immunity (CMI) and complement-fixing IgG antibodies.

Therapy

What does all this mean regarding therapy? In children, at least 40% to 50% of those with warts experience a spontaneous cure. All forms of therapy used, regardless of the type of wart, may effect a 60% to 70% cure rate no matter what type of treatment is applied. Peter Lynch, M.D., Professor of Dermatology, University of Arizona, believes that this is evidence that inflammatory reaction associated with the treatment of warts induces an antibody response. Briefly, the wart treatment program is for children, "from the stars through the thorns." In other words, intensive, painful, destructive therapies are not used initially. Children should be treated with a psychotherapeutic technic before any vigorous cauterizing therapy is used. The initial painless, colorful treatment program therapies include the following technics:

1. Painting any bland-colored material on warts.
2. The diagram technic in which pictures of the involved areas, such as hands, feet, and knees, are drawn by the child. Then bland-colored materials are used on the warts. When pictures are received and patterns and numbers noted on the patient's record, the child is informed by the physician that the wart pictures were examined, counted, and then burned. This approach may prove effective except for the child who thinks it is silly and similar to some other types of folklore therapy.
3. Hypnosis. — The basic mechanisms for the suggestion therapy of hypnosis are not known. This may be vasomotor or an induced antibody response (proof?). It is hoped that the immunologic studies will shed some light on this common form of therapy as well as on the spontaneous cure of warts.

When the therapy program may go from the so-called "scientific" and rational phase into the phase of panic and desperation, the following types of the keratolytic destructive therapy are used:

1. Salicylic acid, 5% to 20%, various vehicles.
2. Formaldehyde, 10% aqueous.
3. Glutaraldehyde, 5% to 10%.
4. Salicylic acid and lactic acid in flexible collodion.
5. Cantharidin, 5-fluorouracil, as cytotoxic agents, nitrogen, mustard, dinitrochlorobenzene (DNCB).
6. Dichloroacetic and trichloroacetic acid, 5%-saturated solution. All these procedures, usually performed in the office, are to be used cautiously in children. Dressings should be applied on all lesions.
7. Topical retinoids, especially for flat warts of the face.

In all treatment programs in which destructive therapy is used, parents should be warned that the areas will become painful. Soreness follows removal of warts. At the same time, Polysporin® or Vioform® may be given to apply to the sensitive lesions. The keratolytic is to be discontinued when the lesions are painful. Warning about a possible reaction and giving medications to

alleviate it will avoid being erroneously blamed for a secondary infection.

A special note should be made of the phase of cytotoxic therapy:

1. Cantharidin.
2. 5-fluorouracil.
3. Nitrogen mustard.
4. Dinitrochlorobenzene acid (DNCB).

For the most part, these therapies should be conducted in the office, not done by a mother even though she is intelligent and interested. To avoid systemic absorption, these materials are to be used only in case of few lesions and then sparingly. Adhesive dressings may be applied. The DNCB therapy is a technic in which the patient is sensitized by an initial application. Repeated applications are made to produce severe inflammatory reactions on the wart lesion. The induced sensitivity may last for a long time. This is one of the "last resort" therapies.

The phase of wart surgery is as follows:

1. Curettement with or without local or general anesthesia; high-frequency electrosurgery may be used after curettement.
2. Cryosurgery.
3. Excisional surgery.
4. Laser surgery.
5. Ultrasonic therapy.

Again, these methods should not be performed unless one has complete experience with such procedures. Due warning should be given about the reactions, scars, and possible recurrences. It is not evident what role psychotherapy plays in those procedures that might

be destructive. Incidentally, the problem with therapy in most warts usually is the lack of controls.

Therefore, warts in the family group should be treated early to prevent the spread of family epidemics. How long should the milder therapies be given before more vigorous therapies are adapted? This is a difficult question to answer. It depends on the individual patient, the tolerance of the parents, and the frustration of the physician. Remember, there is no universally accepted therapy for warts.

Discussion

These treatment programs must be used until further developments in wart immunology are made or until antiviral chemotherapy produces an intracellular viricidal agent specifically for the wart virus but which will not affect the normal cell. Autogenous extracts of warts have been used for years, usually in uncontrolled studies and without associated immunologic studies. Perhaps before that time, the interferon inducers will be available to help to develop immunity in warts.

Although warts are easier to treat in children than in adults, they often present difficult problems of resistance to therapy and spread to the family group. Anesthesia should be considered if destructive therapies are used continuously, especially for extensive warts. It is cruel to cause so much pain to the child; the pain not only may be local but may persist in the psyche. So again, start with the "stars" for years to come. Ambulatory surgery in a proper setting with anesthetists familiar with come-and-go, brief, general anesthesia in children is preferred. It is necessary to cover the lesion with colored adhesive daily to reduce contagion in the family until a spontaneous cure occurs.

Generic and Trade Names of Drugs

Polymyxin B-bacitracin	—	Polysporin
Iodochlorhydroxyquin	—	Vioform

☆☆☆

Recent Concepts in Eye Disease

William H. Havener, M.D.
Matthew Dangel, M.D.

Our purpose is to present a brief review of the most important ophthalmologic developments of the past decade.

Glaucoma

The most preventable cause of blindness still is open-angle glaucoma (also called "chronic simple" glaucoma). Chronic open-angle glaucoma comprises 95% of all glaucoma reported. It results from ultrastructural abnormalities (on the electron microscopic level) of the anterior chamber angle trabecular meshwork. Therefore, these eyes appear clinically normal, are not subject to painful attacks, and are not adversely affected by dilation. The loss of vision is an insidious process occurring over a period of years. Excellent medical and surgical therapy is available and the usual cause of visual loss is the unrecognized disease rather than resistance to treatment. Therefore, early detection and recognition of this disease is critical.

Routine tonometry, advocated in the past as an effective method for early detection, has never gained wide acceptance among family physicians. A rapid, reliable screening test is ophthalmoscopic observation of the cup/disc (C/D) ratio. The C/D ratio is the relative size of the horizontal diameter of the physiologic cup to the optic disc. If, for example, the horizontal diameter of the cup is about one third of the disc diameter, the C/D ratio would be 0.3. The ratio is expressed in

decimals; eg, 0.5 means the cup is half the diameter of the disc. The C/D ratio can be observed easily as part of every ophthalmoscopic examination; it requires no additional time.

Interpretation is easy. A C/D ratio greater than 0.5 will occur in only 5% of the normal population and is characteristic of the atrophic damage caused by glaucoma. Distinction between a large cup occurring as a normal variant and an atrophic cup of glaucoma requires a visual field perimetric examination. This will show characteristic scotomata (pathologic blind spots) if the condition is glaucomatous. Ophthalmologic referral for perimetry is the appropriate management for patients with a C/D ratio greater than 0.5, especially if there is any family history of serious visual problems. The C/D ratio of the two eyes normally is very symmetrical. A difference of more than 0.2 between the C/D ratios of the two eyes almost always represents optic nerve damage. (Memory clues: only 5% of normal C/D ratios exceed 0.5; a greater than 0.2 difference between the two eyes is pathologic.)

For therapy of glaucoma the old standby, pilocarpine, may be replaced by a beta sympathetic blocker, timolol. This agent, recently released (1978), has been highly publicized by the lay press and many patients will inquire concerning its use. Timolol, instilled twice daily as 0.25% or 0.5%, reduces aqueous formation. Timolol does not cause a small pupil as does pilocarpine, therefore the patient does not have undue visual difficulty in the dark or in the presence of nuclear cataract, nor does he suffer accommodative spasm — the local annoying side effects characteristic of pilocarpine.

Diabetes Mellitus

The most common (15%) cause of new blindness in the United States is the development of neovascular membranes upon the surface of the retina. Characteristic of long-standing diabetes (especially of juvenile onset), neovascularization results in destructive bleeding and scarring within the eye. It is thought that the retinal neovascularization is a response to retinal hypoxia which results from the small blood vessel abnormalities

Dr. Havener, Columbus, Professor and Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

Dr. Dangel, Columbus, Resident, Department of Ophthalmology, The Ohio State University College of Medicine and Clinical Instructor of Ophthalmology, The Ohio State University Hospitals.

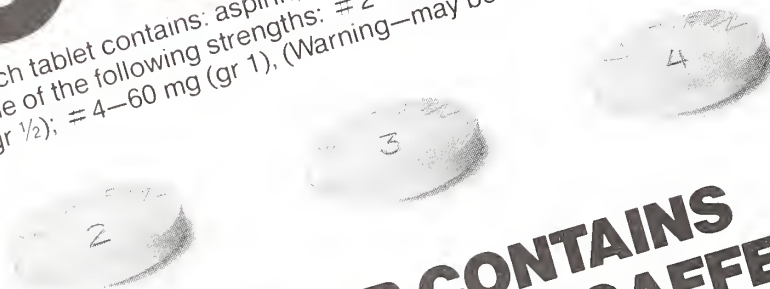
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in diabetes. Standard methods of medical management of diabetes are of no benefit in the care of ocular complications, although it is uncertain whether or not good diabetic control will delay the onset of complications.

Use of the laser is helpful in some cases of diabetic retinal neovascularization and has become widely accepted. The laser acts by destroying hypoxic retina and thereby decreasing the stimulus for neovascular formation. Unfortunately, laser treatment is much less than a panacea, inasmuch as the majority of seriously diseased eyes will become blind despite laser treatment. The prognosis of untreated neovascularization upon or near the disc is that only 15% of eyes will retain 20/200 or better vision after two years. With treatment the prognosis is doubled to 30% which, while an improvement, is by no means the final solution to diabetic retinopathy.

Vitrectomy, the removal of dense scars remaining within the vitreous cavity subsequent to repeated diabetic hemorrhage, has become possible with the use of new instrumentation somewhat akin to a miniature roto-rooter (for cleaning out clogged sewers). The outcome of such surgery is dependent upon the health of the retina, which is hidden from view behind the dense vitreous scars. Hence, even with ultrasonic evaluation, the prognosis is unpredictable in the individual case. Fewer than 50% of eyes will regain as good as 20/200 vision; even these are subject to serious complications such as rebleeding, retinal detachment, and glaucoma.

Ultrasound examination will help to detect eyes in which irreparable retinal detachment exists behind the vitreous scarring. Foreknowledge of such retinal damage will spare the patient a hopeless operation. Diagnostic ultrasound uses the echo patterns of high-frequency sound waves from the posterior globe and orbit to demonstrate various disease processes. The major usefulness of this tool in ophthalmology is in identifying the presence of conditions which would normally be diagnosed with the ophthalmoscope, but are obscured by opaque media. Furthermore, ultrasonic measurement of axial length is important in calculation of the strength of intraocular lens to be used in the optical correction of an eye after cataract extraction.

Retinal Detachment

During the past decade, skills in detection of retinal holes (the cause of retinal detachment) and in closure of these holes have been perfected to the point that postoperative bed rest, pinhole glasses, and disabling restrictions of activity are rarely necessary. Most patients may return to normal self-care at home the first morning after surgery.

Because the visual prognosis depends largely upon whether the diagnosis has been made before the macula becomes detached, it is extremely important that all physicians know the symptoms of early retinal detachment. The sudden onset of many (hundreds) tiny floating soot-like specks (RBCs suspended in the vitreous) probably means that a vitreous hemorrhage has occurred.

One of the most common causes of vitreous hemorrhage is a retinal tear, the precursor of retinal detachment. Elevation (detachment) of the retina begins slowly, usually in a matter of days or weeks, around the location of the peripheral retinal tear and progresses posteriorly towards the macula. The patient recognizes this as a slowly progressive shadow in the peripheral field of vision, gradually advancing toward the center. If the central vision is lost, full normal vision rarely will be restored. Therefore, knowledge of a history of sudden onset of many floating spots followed by a progressive field loss is important in the early diagnosis of retinal detachment.

Conditions particularly predisposing to retinal detachment include myopia, aphakia (following cataract extraction), or the effects of a severe ocular contusion.

Cataract

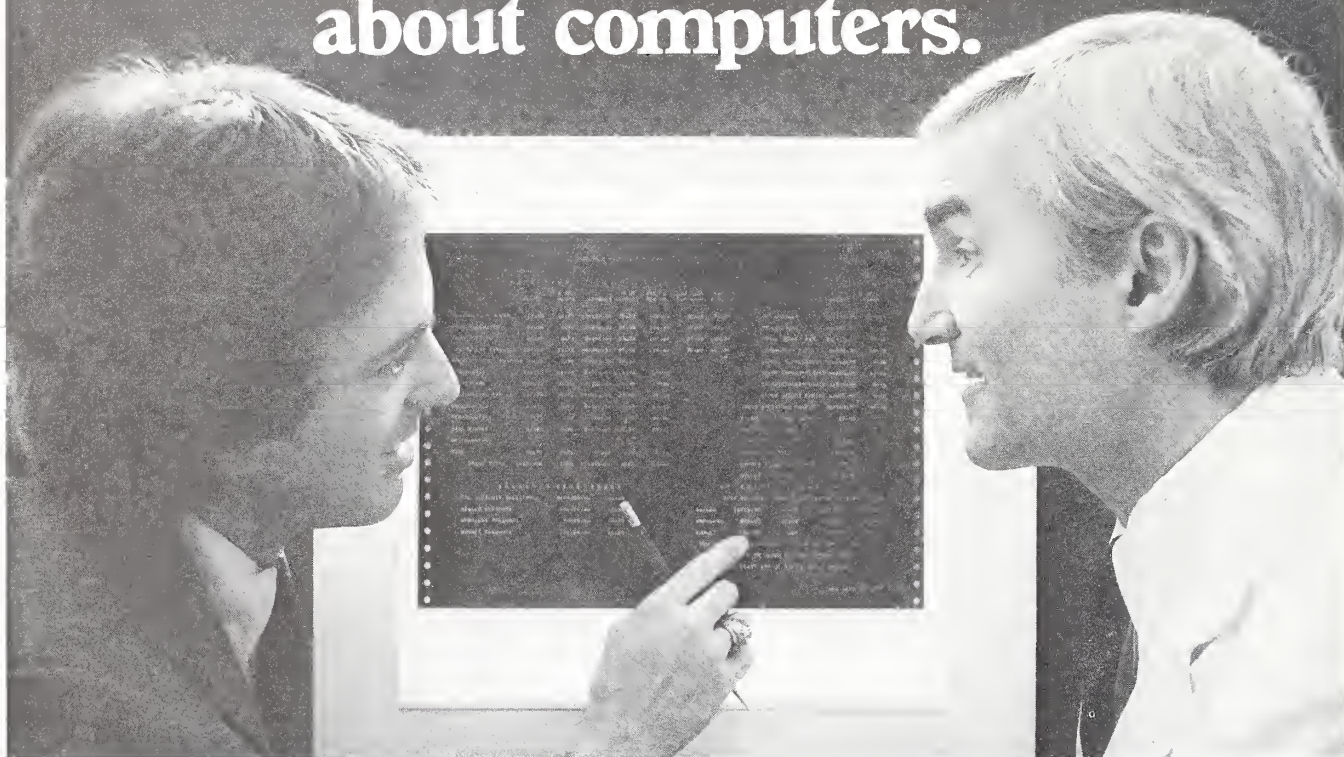
Just as the convalescence from retinal detachment has been greatly reduced, the postoperative course following cataract extraction has become much easier for the patient. This rapid restoration to normal activity is a result of technics employing smaller incisions and improved sutures.

An extremely small incision, only 2 mm, is possible with the phacoemulsifier. This device consists of a hollow irrigation-suction tube containing an ultrasonically activated "hammer" within its lumen. The ultrasound fragments the lens content into a "soup" of fine debris that can be aspirated through the tube.

Another small-incision technic uses the enzyme alpha chymotrypsin to dissolve the zonular fibers holding the lens in position. By means of a cryoprobe (a tiny metal probe which is supercooled by the evaporation of liquid nitrous oxide), the cataract may be gripped securely by the frozen adhesion to the lens capsule. With careful traction and expression, the cataract can be caused to mold itself through a four-hour limbal incision. Closure of the incision with 10-0 nylon sutures secures the wound. This suture is literally a cobweb — 22 microns in diameter — only three times the diameter of a red blood cell. Yet, 10-0 nylon is stronger than steel, on a weight-for-weight basis. It is inert within tissue, inciting almost no inflammatory reaction and resulting in a white (non-inflamed) eye postoperatively.

Traditionally, optical correction of the aphakic eye required the use of convex cataract spectacle lenses which were very heavy. Not only are these cosmetically unattractive and unpleasantly heavy upon the nose, they distort peripheral vision badly and magnify everything approximately 25%, resulting in difficulty in judging distance. These untoward optical consequences result from positioning the corrective lens some distance in front of the eye. Placement of a corrective lens within the eye or directly upon its surface will eliminate these optical problems. An intraocular lens (IOL) is a polymethylmethacrylate lens, calculated to proper strength by keratometric and ultrasonic axial length measurements, and positioned in or near the pupil. Although the use of IOLs has gained

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considerable acceptance, they are associated with a predictably higher incidence of serious complications than those encountered in standard cataract surgery. Perhaps 85% of IOL patients will enjoy a totally uncomplicated convalescence, as compared to more than 95% who underwent standard operations.

Until June 1979, the only alternative to cataract spectacles or an IOL was the daily insertion and removal of a contact lens. Many older patients are physically or emotionally incapable of using a daily wear contact lens. In June, the Federal Drug Administration (FDA) approved the use of extended wear contact lenses for aphakia. An extended wear lens, used in England for almost a decade, is so oxygen permeable so that the cornea can "breathe" through it. This lens may be left upon the cornea day and night for a month or more without removal; it is very thin, relatively fragile, and is inserted and maintained by the ophthalmologist. Regular visits, every month or two, are required to assure that the lens remains clean, oxygen permeable, and well toler-

ated. This is an outstanding advance in contact lens technology and affords both the patient and the ophthalmologist a very welcome alternative in the correction of aphakia. Upon ultimate approval by the FDA for cosmetic use, the extended wear lens may well replace many of the present hard and soft lenses worn by 15 million myopic Americans.

Unlike the presently popular contact lenses, which must be removed from the eyes of unconscious patients, extended wear lenses are tolerated in position for a month or more at a time. In fact an extended wear lens is so thin and transparent that it is essentially invisible to observation upon routine inspection with a flashlight.

While the advances described above have made ophthalmologists better able to deal effectively with ocular disease, developments such as refractive keratoplasty, new pharmacologic agents for glaucoma, improved treatment for diabetic retinopathy, and perhaps pharmacologic treatment for amblyopia are on the horizon and promise even better eye care for the future. ☆☆☆

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Posterior and Anterior Tibial Arterial Bypass Following Tibial Fracture

Thomas E. Williams, Jr., M.D.
 Phillip Catalano, M.D.
 Larry Weis, M.D.
 Robert Stern, M.D.
 John S. Vasko, M.D.

The treatment and management principles concerning an injury involving traumatic disruption of the popliteal artery are described.

ON OCTOBER 22, 1978, a 35-year-old white man was injured when a truck backed into his leg. He sustained a closed comminuted fracture of the left tibia and fibula approximately 2 cm below the level of the tibial plateau. When he was evaluated at a hospital near the scene of the accident, his attending surgeon suspected a major popliteal arterial injury. He was transferred to The Ohio State University Hospital that afternoon. At

the time of his initial examination, he was found to have the previously described fractures with an edematous left leg. Distal pulses could not be obtained on physical examination, but they were clearly audible with a Doppler stethoscope. The consulting orthopedist carried out anterior fixation with a plate. Over the course of the next 36 hours, the leg became more edematous and the pulses obtained with the Doppler stethoscope could not be repeated consistently. Accordingly, an angiogram was obtained, which showed disruption of the popliteal artery (Fig. 1).

The patient was taken to the operating room on the afternoon of October 24, 1978. The popliteal artery

From the Department of Surgery, Lima Memorial Hospital, Lima, Ohio, and the Department of Surgery, The Ohio State University Hospitals, Columbus, Ohio.

Reprint requests to 410 West Tenth Ave., Columbus, Ohio 43210 (Dr. Williams).

Dr. Williams, Columbus, Attending Surgeon, The Ohio State University, Children's, and St. Anthony Hospitals, and Associate Professor of Surgery, Division of Thoracic Surgery, The Ohio State University College of Medicine.

Dr. Catalano, Columbia, South Carolina, formerly Resident in Surgery, The Ohio State University Hospitals, Columbus.

Dr. Weis, Columbus, Attending Surgeon, The Ohio State University Hospitals, and Assistant Professor of Orthopedic Surgery, The Ohio State University College of Medicine.

Dr. Stern, Lima, Attending Surgeon, Lima Memorial and St. Rita's Hospitals, Lima.

Dr. Vasko, Columbus, Attending Surgeon, The Ohio State University, Children's, St. Anthony, and Grant Hospitals, and Professor of Surgery, The Ohio State University College of Medicine.

Submitted June 25, 1979.

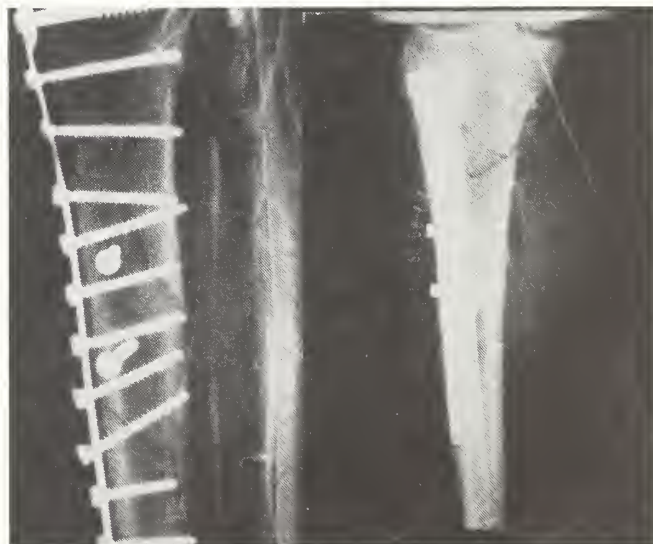


FIG. 1. Anteroposterior and lateral arteriogram showing injury to distal popliteal artery.

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had been destroyed, as indicated in Figure 1. The posterior tibial artery was identified and found to be transected. A Fogarty balloon catheter was used to dilate the artery; adequate back bleeding was obtained. This artery was injected with heparin-saline solution. The transected anterior tibial artery also could be identified, and was treated similarly. A great saphenous vein was harvested from the right groin, reversed, and attached as an end-to-end anastomosis to the posterior tibial artery. The end of the anterior tibial artery was anastomosed to the side of the vein graft. The proximal end of the vein graft then was anastomosed to the side of the popliteal artery at a somewhat higher level. When the clamps were released, a good pulse was obtained in both distal vessels. An extensive fasciotomy was carried out to decompress the leg. Nonviable tissue was radically excised. The vessels were covered with viable muscle and fascia. The entire area was irrigated with copious amounts of antibiotic and diluted Betadine® solutions. Large, bulky, Betadine-soaked dressings were applied. Following the bypass procedure, venous compromise of the leg was noted. The leg was elevated and he was treated with low doses of heparin. The swelling gradually receded, and the fasciotomy area was covered with split-thickness skin grafts. A postoperative arteriogram was obtained (Fig. 2). The patient was fitted for Jobst's stockings and anticoagulation therapy with Coumadin® was begun. When he was discharged from the hospital, he was ambulatory but unable to bear full weight on the leg. On subsequent follow-up visits, he has been found to have palpable dorsalis pedis and posterior tibial pulses on the injured side. The grafted area has healed nicely and it is evident that the bone is healing well.

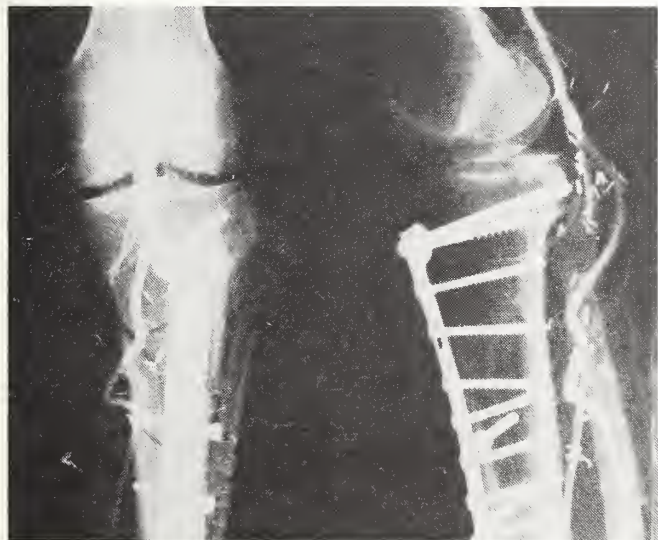


Fig. 2. Anteroposterior and lateral arteriogram showing saphenous vein graft to posterior and anterior tibial arteries.

Discussion

Popliteal artery injuries are challenging problems. A history of significant leg injury should arouse a high index of suspicion for arriving at this diagnosis. The absence of pulses can confirm it. An examination showing decreases or losses of pulses must be interpreted as evidence of disruption of the arterial system and as an indication for emergency angiography.^{1,2} Patients presenting with these symptoms must be explored at the earliest possible time in order to prevent clotting of the arterial tree, which would preclude successful grafting.³ In such cases, the blood vessels in these patients usually have not sustained arteriosclerotic changes and are very suitable for anastomosis.⁴ The vein graft should be harvested from the other leg, preserving venous integrity of the injured extremity.

Stabilization of the fracture should be carried out at the earliest possible moment. Instability of the fracture may compromise an otherwise successful vascular repair.

Because of the massive crushing occurring in these injuries, decompression of the entire calf by fasciotomy is warranted.^{1,5,6} Nonviable tissue should be debrided and vessels should be covered with viable tissue. Delayed closure or skin grafting will provide skin coverage.

For patients with these injuries, we believe that postoperative noninvasive, Doppler arterial pressures and wave forms and arteriograms are indicated. They will serve as a baseline for evaluation of the reconstruction at a later time.

The venous insufficiency and the concomitant hazard of pulmonary embolism seen with these injuries should be treated in the acute phase by elevation of the leg and heparin therapy. Leg support with Jobst's stockings is used to minimize the long-term effects of venous insufficiency. Anticoagulation therapy with Coumadin® for six months postoperatively was planned to minimize the likelihood of pulmonary embolism.

Summary

Traumatic disruption of the popliteal artery poses very serious problems. Successful management requires a high index of suspicion for the diagnosis, early stabilization of the fracture, arteriographic confirmation of the injury, decompression of all compartments by extensive fasciotomy, aggressive treatment of concomitant venous injuries, and close long-term follow-up for these patients.

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References

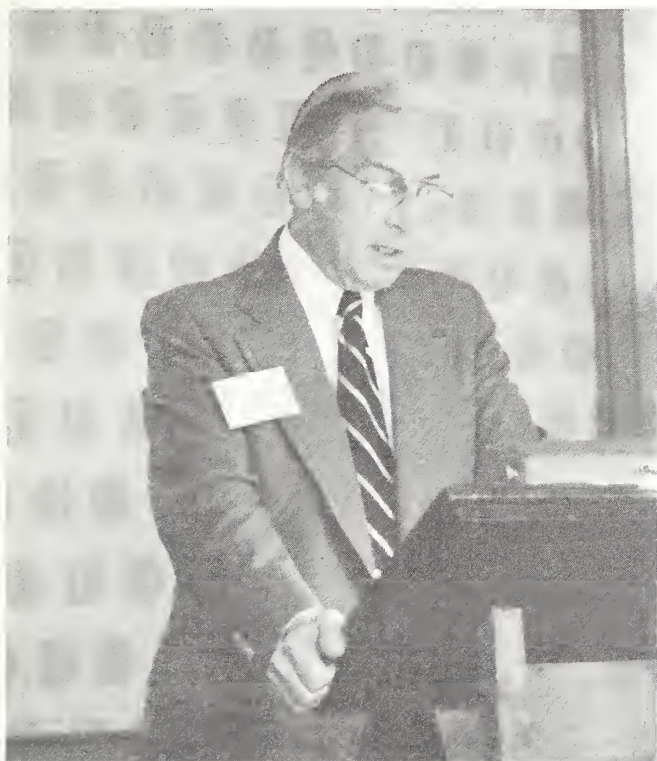
1. Solheim J, Gronmark T, Rosseland A, et al: Popliteal vessel injury. *Acta Chir Scand* 142:579-584, 1976.
2. Miles JT, Dela Rocha AG, Baird RJ: Current approaches to popliteal artery repair. *Can Med Assoc J* 116:606-608, 1977.
3. Daugherty ME, Sachatello CR, Ernst CB: Improved treatment of popliteal arterial injuries. *Arch Surg* 113:1317-1321, 1978.
4. Evans WE, Bernhard VM: Tibial artery bypass for ischemia resulting from fractures. *J Trauma* 11:999-1007, 1971.
5. Houck WS Jr: Blunt trauma to the popliteal artery: a review and presentation of four cases. *Am Surg* 43:434-437, 1977.
6. Dart CH Jr, Braitman HE: Popliteal artery injury following fracture or dislocation at the knee. *Arch Surg* 112:969-973, 1977. ☆☆☆

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John W. Coury, M.D., Member, Board of Trustees, AMA
Story and Photographs by Cheryl A. Zaruba

OSMA President Thomas Morgan, M.D., presided over a special meeting attended by 75 county medical society presidents, executives, OSMA officials, the Council, and Ohio delegates to the AMA.

The meeting was held to fulfill the requirement set forth in Substitute Resolution No. 3-78 which called for *Improved Communication Within the OSMA*. (July 1978, Journal page 461.)

Doctor Morgan, along with the OSMA staff, reviewed Association activities including: OSMA 1980 Annual Meeting, State and Federal legislation, and membership goals. John W. Coury, M.D., Member, Board of Trustees, AMA, reviewed AMA problems and activities.

"Every physician has an obligation to join organized medicine," said Doctor Coury. He discussed the declining AMA membership and the potential repercussions of this decline, emphasizing that a membership decline affects *all* physicians, not just current AMA members. Doctor Coury pointed out that, "Unfortunately many physicians

are taking a free ride," since nonmembers reap political and educational benefits from AMA at no charge, while dues-paying members carry the burden of the expense.

Although some nonmembers resist the cost of joining AMA, the speaker noted that AMA dues are less than those paid by airplane pilots and teamsters who join their respective professional associations.

Doctor Coury explained that each person must take an "eyeball-to-eyeball" approach when recruiting new members. He urged OSMA members to contact their colleagues directly and point out the potential benefits of membership.

In addition to the political and educational benefits, Doctor Coury stated, "If there is *one* thing it (AMA) has done, it has provided you with a retirement plan, and that through AMA efforts, members are now able to incorporate and retire in comfort with the Keogh plan."

Doctor Coury emphasized the importance of involving young physicians, including residents and students, in medical organizations. "The future is theirs, and the actions we physicians take today will determine the course of their careers in the years to come."

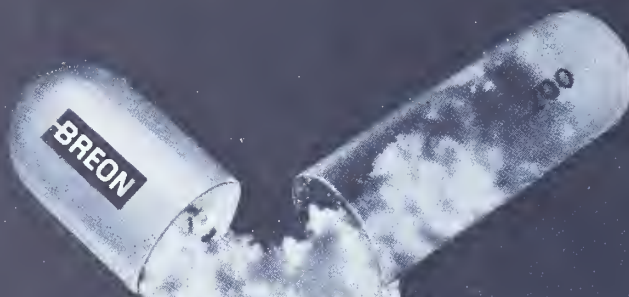


Robert N. Smith, M.D., Vice Chairman, AMA Delegation

Doctor Coury also discussed Report "B" of the AMA Council on Long Range Planning and Development. Figures in the report indicate that 20,000 new AMA members must be recruited each year to avoid a dues increase. (A full report on Report "B" will be included in the March issue of The Journal.)

A brief account was given of the proposed revisions in the AMA Code of Medical Ethics. According to Doctor

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WARNINGS: Theophylline should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

arrhythmias may be worsened by theophylline.

Usage in Pregnancy: Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

Theophylline should not be administered concurrently with other xanthines.

Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

ADVERSE REACTIONS: Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. *Gastrointestinal:* nausea, vomiting, epigastric pain, hematemesis, diarrhea. *CNS:* headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. *Cardiovascular:* palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. *Respiratory:* tachypnea. *Renal:* diuresis, albuminuria. *Other:* hyperglycemia, inappropriate ADH

secretion.

Drug Interactions: Toxic synergy with ephedrine and other sympathomimetic bronchodilators may occur.

OVERDOSAGE Treatment:

A. If potential oral overdose is established and seizure has not occurred: 1) Induce vomiting. 2) Administer a cathartic. 3) Administer activated charcoal.

B. If patient is having a seizure: 1) Establish an airway. 2) Administer O₂. 3) Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg. 4) Monitor vital signs, maintain blood pressure and provide adequate hydration.

C. Post-seizure coma: 1) Maintain airway and oxygenation. 2) If a result of oral medication, follow above recommendations to prevent absorption of drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube. 3) Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as to not warrant consideration of dialysis.

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(left) Thomas Fox, M.D., Stewart Dunsker, M.D.,
David Barr, M.D.

Coury, the basic principles of the current medical ethics should not be changed; however, the wording of the ethics must be revised in order to avoid potential legal complications.

Oscar Clarke, M.D., Chairman, Ohio Delegation, House of Delegates, AMA, said, "The problem the Ohio delegation has is trying to find out the wishes of our people." He emphasized that all OSMA members have input and urged physicians to make their views known to the delegation. In reference to physicians who refuse to join the AMA, Doctor Clarke said most disturbing are those who choose not to belong because of *one issue*. "With such a heterogenous group it is impossible to agree on all issues. It is unfair to make a decision not to join the AMA based on *one issue*," he said.

Chairman of the OSMA Committee on State Legislation, C. Douglass Ford, M.D., Toledo, asked all members to help the OSMA identify persons who have direct contact with legislators. In a letter to be sent to all county medical society presidents, Doctor Ford said "... the unrelenting succession of new legislative proposals which threaten our system of quality medical care will not end or even slow in the near future. Consequently, OSMA must augment its legislative efforts with more direct and personal contacts by our physician members."

D. Brent Mulgrew, Director, OSMA Department of State and Federal Legislation, closed the meeting with an overview of current legislative activities. (See December 1979 Journal-Legislative Update, pages 739 and 740.) Mr. Mulgrew explained that the new Abortion Bill is the most controversial bill in the State legislature. Under the proposed bill the entire burden of informed consent is placed on the physician.

The meeting was adjourned following a brief question and answer period.

Infant Formulas

Submitted by HEW

Over the past several months, infant formulas have been involved in an increasing number of health-related problems, ranging from nutrient deficiencies to processing breakdown. These events have served to focus attention on procedures necessary to assure the quality and safety of these products.

FDA advises that all hospitals and other health facilities immediately begin to evaluate their procedures for storage, distribution, and preparation of infant formulas to identify possible points of contamination and/or reduction in nutritive value.

In addition, FDA needs to have more information on infant illnesses in which formulas may be implicated. The Agency would welcome information on the clinical nature of such illnesses, any supportive laboratory findings, the product or products that may be involved, the time that the problem occurred, and the length of time the formula was used. This information should be sent to FDA's Bureau of Foods, HFF-1, 200 C Street, S.W., Washington, D.C. 20204.

FDA is reevaluating its procedures for assuring the quality and nutritional efficacy of infant formulas. The Agency is considering the establishment of standards for nutritional quality, as well as development of procedures for requiring premarket clearance of such formulas.

FDA also is considering the establishment of required quality assurance checks as part of good manufacturing practice for each such product. Early in 1980, FDA will hold the first of a series of international conferences to determine which nutrients need to be checked routinely and which nutrients need to be evaluated only under special conditions. In addition, these conferences will explore the scientific basis for construction of these standards.

In 1977, there were 194 physicians per 100,000 population in the United States, 47 surgeons per 100,000 population, and 65 primary care physicians per 100,000 population.

Of the 421,278 physicians in 1977, 41,459 were women, 86,789 were foreign medical graduates, and 19,926 were federally employed. Of the 101,153 surgeons in 1977, 3,720 (4%) were women, and 17,381 (17%) were foreign medical graduates.



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HERMAN I. ABROMOWITZ, M.D., Dayton, was appointed OSMA Councilor from the Second District to replace **W. JACK LEWIS, M.D.**, Dayton, who recently was elected to the AMA Board of Trustees.

YING AMORN, M.D., Youngstown, was named a Fellow of the American College of Gastroenterology. Dr. Amorn is an internal medicine and gastroenterology specialist on the clinical staff of St. Elizabeth Hospital Medical Center.

CHARLES R. BLOCK, M.D., Columbus, was appointed medical director of Mid-Ohio Health Care Plan. It is a health maintenance organization being developed in affiliation with Blue Cross of Central Ohio and Ohio Medical Indemnity Mutual Corporation.

Past president of the AMA, **JOHN H. BUDD, M.D.**, Cleveland, was appointed chief consultant of medical affairs for Blue Cross of Northeast Ohio.

EDWARD R. CERUTTI, M.D., Cleveland, received a special recognition award from the La Leche League International for his promotion of breastfeeding and his help beyond the call of duty to nursing mothers.

Six OSMA members from Youngstown and Trumbull counties were initiated as Fellows in the American College of Surgeons: **DANNY K. B. CHUNG, M.D.**, Hubbard; **ROBERT W. TAYLOR, M.D.**, Warren; **A. B. CINELLI, M.D.**, **GEORGE B. PUGH, M.D.**, **NARENDRA K. BADJATIA, M.D.**, and **ALFRED R. HOFFMASTER, M.D.**, Youngstown.

The American Board of Surgery has certified **ORLANDO R. CASTRO, M.D.**, East Liverpool.

BENJAMIN C. HUMPHREY, M.D., Carroll, was appointed to the Wagnalls Memorial board of trustees.

The American Association of Professional Standards Review Organizations (AAPSRO), elected **GEORGE P. LEICHT, M.D.**, Cleveland, as vice-president of the organization.

STEVEN LICHTBLAU, M.D., Columbus, was appointed medical director of First Community Village. **ROBERT MURPHY, M.D.**, and **PAUL KEITH, M.D.**, Columbus, were named associate medical directors.

WILLIAM T. MARTIN, M.D., Massillon, **GEORGE W. KMETZ, M.D.**, and **DAVID B. STIRES, M.D.**, Canton became Fellows of the American College of Surgeons.

ALBERT N. MAY, M.D., Marion, was elected a charter member of the section on adolescent health, part of the American Academy of Pediatrics.

DAVID I. MUSKAT, M.D., Bellaire, was appointed medical director of the Community Mental Health Services of Belmont, Harrison, and Monroe counties.

STANLEY W. OLSON, M.D., Rootstown, resigned as consultant and Professor of Medicine at Northeastern Ohio Universities College of Medicine (NEOUCOM). Dr. Olson was the first Provost and founding father of NEOUCOM. He expects to do a lot of fishing in retirement, travel with his wife, Lorraine, and continue to act as consultant when an interesting problem in medical education is presented to him.

JAMES OTIS, M.D., Celina, was awarded a silver plaque in recognition of 20 years of service to the Heart Association. **DONALD FOX, M.D.**, Celina, also was awarded a plaque for 15 years of service.

(Continued)

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RAJ PATEL, M.D., Xenia, was granted a fellowship in the American College of Chest Physicians. Dr. Patel is board certified as a chest physician and in internal medicine.

H. WILLIAM PORTERFIELD, M.D., Columbus, was elected vice-president of the American Society of Plastic and Reconstructive Surgeons. Dr. Porterfield is a past president of the Academy of Medicine of Columbus and Franklin County. He currently serves as an Ohio Delegate to the American Medical Association.

VICTOR A. SIMIELE, M.D., Lancaster, received an award from the Morrow County Unit of the American Cancer Society for distinguished service in cancer control.

F. MASON SONES, M.D., Cleveland, was named a Distinguished Fellow of the Cleveland Clinic Foundation's International Center for Specialty Studies. Dr. Sones is a cardiologist at the Clinic.

ROBERT G. THOMAS, M.D., Elyria, OSMA president-elect was elected Speaker of the House of Delegates of the American College of Pathologists.

CHARLES TWEEL, JR., M.D., Upper Arlington, was named a Diplomate of the American Board of Family Practice as a result of passing a certification examination.

OSMA members, **GARY L. WHITACRE, M.D.,** **EDWARD J. BALTES, M.D.,** Columbus, and **WILLIAM T. BACON, M.D.,** Madison, were named Fellows of the American Academy of Family Physicians.

The Heart Association presented **THEODORE H. WILL, M.D.,** Minster, with an award in recognition of his 25 years of service to the Association and 50 years of medical practice as a family physician in the Auglaize County area.

The American Cancer Society, Ohio Division, Inc., has appointed **PAUL R. ZEIT, M.D.,** Cleveland, as chairman of the Special Projects Committee of the Society.

As chairman, Dr. Zeit will coordinate the review of projects conducted by the Society in Ohio which are of special significance and require funding.

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AMERICO D'AMICO, M.D., Steubenville; Facolta di Medicina e Chirurgia dell'Universita di Napoli, Napoli, Italy, 1945; age 58; died November; member OSMA and AMA.

RALPH D. DOOLEY, M.D., Newark; University of Cincinnati College of Medicine, 1924; age 81; died November; member OSMA and AMA.

HAROLD V. ELLINGSON, M.D., Columbus; University of Wisconsin Medical School, Madison, 1941; age 66; died October 25; member OSMA and AMA.

JAMES KNOX GIBSON, M.D., Cambridge; University of Pennsylvania School of Medicine, Philadelphia, 1926; age 77; died November 13.

BERNARD J. GOLDFARB, M.D., Fair Oakes, California; Fordham University School of Medicine, New York, 1921; age 80; died October 30; member OSMA and AMA.

WILLIAM A. KOEHLER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1921; age 84; died October 26; member OSMA and AMA.

THEODORE A. KRUTKY, M.D., Akron; New York Medical College, New York, 1933; age 72; died November 2; member OSMA and AMA.

NORMAN LAVINE, M.D., Cleveland; Wayne State University School of Medicine, Detroit, 1926; age 83; died November 4; member OSMA and AMA.

JOHN A. MACZUGA, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, 1932; age 75; died November 10; member OSMA and AMA.

JOHN H. NICHOLS, M.D., Oberlin; Rush Medical College, Chicago, 1916; age 89; died November 6.

GUY W. TALMAGE, M.D., Toledo; University of Michigan Medical School, Ann Arbor, 1954; age 61; died October 27; member OSMA and AMA.

CHARLES E. VAN MASON, M.D., Cleveland; University of Cincinnati College of Medicine, 1928; age 84; died October 11; member OSMA and AMA.

WILLIAM N. VIGOR, M.D., Cleveland; Case Western Reserve University, Cleveland, 1944; age 77; died October 25.

ARCHIE W. WARREN, M.D., Los Angeles, California; Case Western Reserve University, Cleveland, 1916; age 93; died October; member OSMA and AMA.

SANFORD ZIEVE, M.D., La Habra, California; The Ohio State University College of Medicine, 1937; age 67; died October 16; member OSMA and AMA.

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SCIENTIFIC EXHIBITS WANTED

1980 OHIO STATE MEDICAL ASSOCIATION ANNUAL MEETING

Do you have a scientific exhibit or know of one which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1980 OSMA Annual Meeting. The eligibility is as follows: Scientific Exhibits will be limited to those presentations developed by members of the OSMA. Exceptions will be considered by the Exhibit Screening Chairman if any exhibit is deemed to be of special interest or educational benefit to members of the OSMA. The latter shall not be eligible for any awards or ranking by the OSMA, but shall be designated as of "special merit."

Exhibit Space will be limited this year and booth assignment will be made on first come, first serve basis.

Exhibits will be set up and viewed on the second floor at the Cincinnati Convention Center, 200 West Fifth Street, Cincinnati, Ohio 45202. The Exhibit days and times will be as follows: Monday, May 12 - 9:00 a.m.-4:00 p.m.; Tuesday, May 13 - 9:00 a.m.-4:00 p.m.; Wednesday, May 14 - 9:00 a.m.-4:00 p.m.

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Cincinnati Convention Center, Cincinnati, Ohio, May 12, 13, & 14

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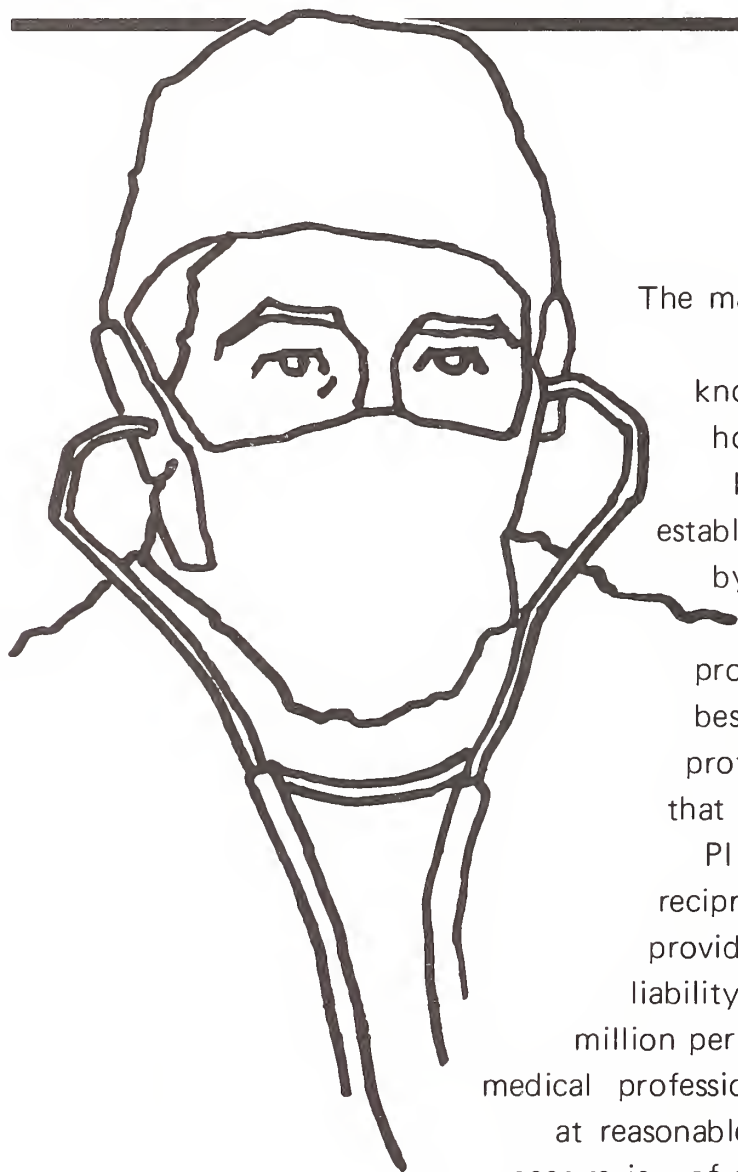
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COVER: This photograph, "Morning Tranquility," won an Outstanding Entry Award in the 1979 Ohio State Medical Journal Photographic Exhibit. Photographer Vera Kalnins, wife of Dr. Kalnins, Bucyrus, captured this picture with her Nikon F2 Fotomic. (Lens 500mm Nikkor Reflex, Aperture - F8, Film - Ektachrome 200)

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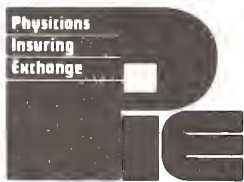
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Questions Physicians Should Ask About HMOs and IPAs

The California Medical Association has prepared a leaflet entitled, "Questions Physicians Should Ask About HMOs and IPAs." The growing number of Health Maintenance Organizations and Individual Practice Associations may cause physicians to be faced with questions about their response to such developments. A decision to participate or not can be extremely important. The booklet contains several questions physicians may raise regarding organization, demographics, professional relationships, financial/legal considerations, your commitment, choice among multiple options, and the bottom line.

If you would like a copy of this leaflet, contact the OSMA Department of Government Relations.

Slow Medicaid Payments

The Ohio Department of Public Welfare is experiencing difficulties in processing Medicaid claims. It is hoped by the time you read this that the backlog of unpaid claims will be reduced greatly. Over 50,000 claims, covering billings for September and October 1979, have been processed and payment should be made by early February.

Much of the problem relates to claims not being prepared sufficiently. If not completed correctly for the optical scanner, claims must be keypunched to conform to the state computer, causing delay. The turnaround time for a claim appropriately filled out is approximately 30 days. It might be worth your billing secretary's time to review the instructions for filling out a Medicaid claim form.

Part B Premium Up Again

Starting July 1, 1980, the premium for Medicare's Part B Supplementary medical insurance coverage will be \$9.60. This is an increase of \$.90 over the current premium of \$8.70. When the Medicare program started in 1966 the monthly premium was \$3.

HEW to Encourage Second Opinions

HEW announced an information campaign to encourage people to get a second medical opinion before undergoing nonemergency surgery. The campaign is aimed at reducing *unnecessary surgery*. HEW, in announcing this campaign, reported the first-year results of a three-year project they have funded in New York showing that 31% of 1,464 cases recommended for surgery were not confirmed by physician consultants giving second opinions.

HEW Proposes Rules on Verification of Services

HEW's Health Care Financing Administration published in the Federal Register proposed rules to establish a uniform system for verifying whether Medicaid recipients received services for which Medicaid was billed. A minimum of 300 recipients per month per state will be asked to verify whether services billed actually were rendered. Verification notices would not specify confidential services.

Regulations and More Regulations

Under the requirements of a Presidential Executive Order on Improving Government Regulations, each federal agency must, twice a year, list in the *Federal Register* significant regulations under development. There were 55 such items under the Health Care Financing Administration and 82 under the Public Health Service.

Over 2,305 pages (3 columns per page) of regulations, proposed regulations, and notices to propose regulations appeared in the *Federal Register* this year just through January 10.

Physician HSA Involvement

OSMA Districts Four and Eleven have formed a new physician health planning consortium to provide direct physician involvement in the health planning process. Physicians representing medical societies of Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, and Wood Counties met to discuss recent developments proposed by the area Health Systems Agency, Health Planning Association of Northwest Ohio. Subsequent meetings are planned to discuss specific areas such as obstetrical beds, pediatric, and neonatal intensive care units, and a proposal from HPA that identifies alleged excess acute-care beds.

In Districts Seven, Eight, and Nine preliminary meetings are being held to consider the formation of a physician consortium within the boundaries of Health Systems Agency Six, located in Marietta. Ratification of the physician consortium concept, to provide an avenue of direct physician input to the planning process in the Marietta area, would bring the statewide consortium total to four, with a total of 43 county medical societies represented.

For assistance or a more detailed explanation of the Association's involvement in health planning, please contact: David W. Pennington, Department of Government Relations, OSMA.



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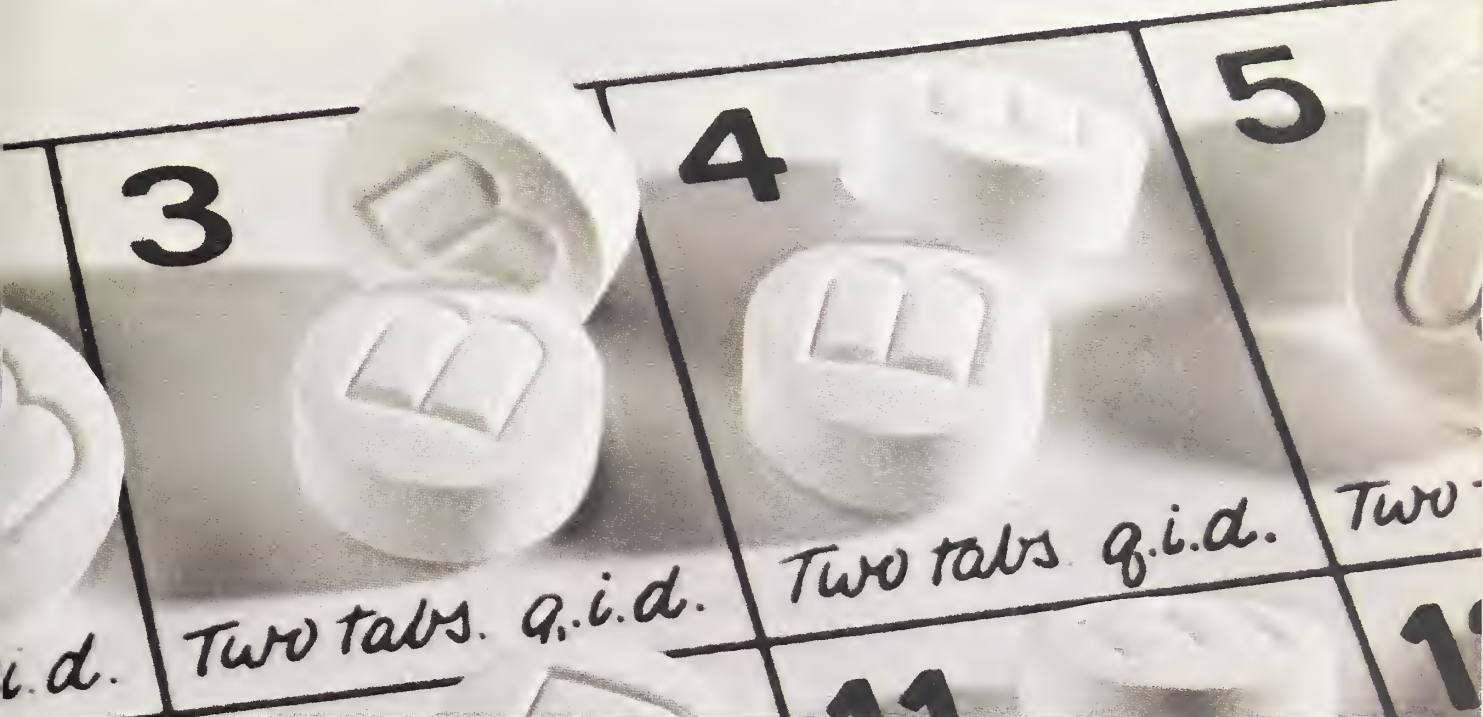
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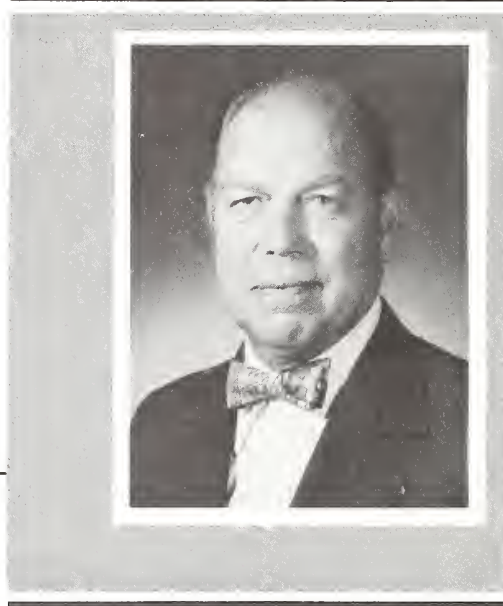
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PRESIDENTIAL PERSPECTIVES



Thomas W. Morgan, M.D.
President

COMMUNICATIONS, CREDIBILITY, AND PUBLIC IMAGE Last year's OSMA membership survey provided a fascinating insight into the way doctors view the public relations problems of their profession.

Although medicine continues to lead all professions in the "Who is most Trustworthy Derby," physicians generally are becoming increasingly more aware and concerned that their public image and confidence have been eroding in recent years. Many physicians feel their present poor public image is the result of an incessant flow of false or misleading statements from the government which then are reported by a biased media as true facts. Others advance the opinion that inadequate communication between physician and patient, and also between the medical profession and the public via the news media, account for a large share of the problem. It is likely that both opinions are well founded.

Our patients' need for information and advice on health care definitely extends to political and socioeconomic medical issues. But they want to hear more about them from their physician, someone they trust, rather than from the government and the media whose credibility seem to be steadily decreasing in these matters.

It would seem that we not only have an opportunity but an obligation to utilize our patients' confidence in us to provide accurate information on health care issues to the public.

Although direct discussion between the physician and each patient is the ideal answer to the problem, it obviously is impractical and probably physically impossible except on a very limited scale.

In response to this clear need for more effective physician/patient communication, the Officers and Council of the OSMA have initiated some new public relations policies designed to facilitate the transmittal of medicine's views to the public.

It was primarily for this purpose that our newest monthly publication, *Synergy*, was conceived. *Synergy* can help physicians inform their patients while at the same time free them from spending so much time doing it on a one-to-one basis.

Also, we strongly recommend that county medical societies seek a closer, more cooperative relationship with the local news media. This might take the form of an informal meeting with media representatives sponsored by the medical society for a frank discussion of how to achieve greater local physician input into medical news stories. County societies should offer assistance to the media and establish a reliable "hot line" for convenience of the media in providing a contact when a news story with medical overtones is breaking. Often a negative story gets told simply because the newsperson cannot find a physician willing to comment.

In an effort to encourage such activities, the Communications Department of the OSMA is prepared to meet at any time with county officers to help set up a PR or Community Relations Program.

The Officers and Council also have taken the position that increased dialogue among physicians themselves concerning political and socioeconomic affairs will stimulate greater interest in crucial issues and lead to a better-informed profession. Accordingly, we are presently initiating a Letters to the Editor section in the *OSMA Journal* along with a column in which two physicians would debate both sides of a controversial issue. Guidelines for these innovations are included elsewhere in this month's *Journal*.

Issues raised in our Presidential Perspectives Column have stimulated many interesting responses, both positive and negative. We appreciate this interest and encourage your continued response.



STATE

OSMA Successful in Amending Licensure Bill

The OSMA succeeded in amending House Bill 753, the proposed hospital licensure bill, to ensure that Ohio's hospitals maintain the requirements that only physicians and dentists can admit patients. The OSMA amendment also requires that "all patients admitted to a hospital must be under the medical supervision of a physician." The amendment to the definition was accomplished through the cooperation of the bill's sponsor, Representative John D. Thompson (D-Cleveland). The bill was recommended favorably for passage and sent to the House Rules to be scheduled for consideration by the full House.

House Bill 753 had been in subcommittee for the past three months and plagued by definitional problems. There have been repeated efforts by nonmedical personnel (ie, psychologists and physical therapists) to be included in the legislation and obtain staff memberships with admitting privileges and supervisory responsibility. The Committee refused to consider this amendment in full committee after being defeated twice in subcommittee.

In addition, the Ohio Attorney General, William J. Brown, and his representatives have clashed with the OSMA over this issue. The Attorney General argued against the amendment requiring hospital admissions by physicians and inpatient care be under the medical supervision of a physician. He argued these requirements could violate his interpretation of federal antitrust laws, although no opposition testimony was presented before the full committee. In a related development, on December 4, 1979 the Attorney General filed an antitrust suit against the JCAH of conspiring "to suppress and eliminate psychologists from competing with physician providers of psychological care in JCAH accredited facilities and program." The OSMA has been named as a co-conspirator in the antitrust suit. The suit filed in the U.S. District Court for the Southern District of Ohio, asks the court to permanently enjoin JCAH from adopting or enforcing any policy which prevents psychologists from providing care in JCAH accredited facilities as fully as their licenses permit.

The OSMA will be working to maintain the excellent language presently contained in House Bill 753 on the House floor and in the Senate consideration of HB 753. Physicians should contact their local legislators and urge

they support the requirement that physicians admit patients and supervise the medical treatment of patients in a hospital. It is expected the Ohio Psychological Association and Physical Therapy Association will continue to push for nonmedical practitioners to obtain hospital admission privileges.

Marijuana Therapeutic Research Bill Receives Hearing

Hearings have begun in the House Judiciary Committee on Senate Bill 184 (Stano D-Parma) proposing a four-year therapeutic research program for the limited use of marijuana for medical purposes. Senate Bill 184 was approved overwhelmingly last year by the Ohio Senate and is supported by the OSMA, provided it contains appropriate medical monitoring safeguards for a research program.

The legislation requires the Director of Health to administer the program to research the medicinal uses of marijuana and the Public Health Council to adopt the rules. The rules provide for the inclusion of glaucoma patients and patients undergoing chemotherapy or radiation treatments for cancer. The Director is given authority to contract with the Ohio State University to conduct research during the four-year period.

A Patient Review Board for the Controlled Substances Therapeutic Research Program would be established, consisting of three board-certified physicians, an ophthalmologist, an oncologist, and a psychiatrist. Applications to serve as a research subject for the program would be made to the Patient Review Board. The Board would certify patients who meet established criteria in accordance with the rules.

Testimony has been presented to the committee in support of Senate Bill 184 by James Neidhart, M.D., an oncologist at the OSU Cancer Clinic who testified that he has had positive results utilizing marijuana in treating the nausea of chemotherapy for some of his patients. The OSMA testimony emphasized that the OSMA does not support the legalization of marijuana but it does support the carefully evaluated research program with appropriate medical input and monitoring safeguards of the limited program.

Testimony in opposition to the inclusion of glaucoma patients in the program was presented by Fred Kapetansky, M.D., an ophthalmologist in Columbus. Dr. Kapetansky told the Committee members that the devel-

opment of a new drug Timolol has proven to be remarkably effective in the treatment of glaucoma and he questioned the propriety of utilizing marijuana in the treatment of glaucoma.

Senate Bill 184 will be considered by the Judiciary Committee and brought to the floor for a vote by the full House.

Abortion Bill Sent to Judiciary Committee

Representative Ken Rocco (D-Parma) has introduced House Bill 879 establishing a new set of state regulations on the performance of abortions. The legislation would regulate physicians and abortion facilities, and would attach civil and criminal penalties for violation of its provisions. HB 879 was referred to the House Judiciary Committee for consideration.

HB 879 apparently is a modification of the controversial Akron abortion ordinance, which has been used as a model for legislation in several states. The Bill would prohibit abortion after 24 weeks of gestation, unless the unborn child is not viable or the physician can document that the abortion is necessary to *preserve the life or physical or mental health of the pregnant woman*. In an abortion of a viable unborn child, a second physician would have to be present to take all reasonable measures to preserve the life of the child.

New informed consent provisions require that certain statutorily described information would have to be orally imparted to the patient by the physician, including a description of the development of her unborn child and possible *serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility, or miscarriage . . .*

The bill also would require parental consent for abortion upon an unmarried woman under 16 years of age. After the first trimester of pregnancy, any abortion would have to be performed in a hospital. In addition, the bill expands the statutory reporting and record requirements of physicians and abortion facilities and mandates local health departments to physically inspect abortion facilities twice a year.

In late August, United States Judge Leroy Contie struck down several similar provisions in the Akron ordinance as unconstitutional. HB 879 should begin receiving hearings soon in the House Judiciary Committee.

"Death with Dignity" Bill to be Introduced

Legislation will be introduced into the General Assembly to permit terminal patients to refuse life-

prolonging measures by executing so-called *living wills* and to protect health care personnel from criminal or civil liability or professional censure for withholding or withdrawing such measures in certain cases. The bill was drafted by a Columbus-based group, the *Association for Freedom to Die*.

The bill statutorily establishes three situations in which a physician is shielded from liability for withholding life-prolonging measures from terminal patients: (1) In the case of terminal patients who currently are able to make and express their decisions regarding treatment and who decide against the use or continuation of life-prolonging measures; (2) in the case of terminal patients who are no longer able to make and express their decisions regarding treatment but who previously have executed living wills stating their wish to have life-prolonging measures withheld or withdrawn when they become terminal; (3) in the case of terminal patients too ill to make and communicate their decisions regarding treatment and who have *not* executed living wills: (a) provided that the near relatives who have been in communication with the attending physician unanimously agree that life-prolonging measures should be withheld or withdrawn; or (b) provided that no near relatives have communicated with the attending physician despite his or the hospital's reasonable efforts to reach them; or (c) provided that a near relative has obtained a court order authorizing the withholding or withdrawal of life-prolonging measures.

This legislation follows activity in ten other states that have enacted laws giving legal recognition to living wills and protecting health care personnel who honor them.

Department of Mental Health and Mental Retardation to be Divided

Representative Myrl Shoemaker (D-Bourneville) introduced legislation to reorganize the Department of Mental Health and Mental Retardation into two new state agencies. House Bill 900 would establish a Department of Mental Health and a Department of Mental Retardation and Developmental Disabilities.

House Bill 900 has the support of Governor Rhodes' Administration and legislative leaders. During the bill's first hearing in the House Finance-Appropriations Committee, Chairman Shoemaker indicated that although he doubts there will be significant savings realized by this move, he hopes that the separation of the agency functions will improve service to Ohio's communities and reduce administrative overlap.

As hearings on HB 900 continue through the month of February, the proposal will be reviewed by the OSMA Committee on State Legislation.

(Courtesy Department of State and Federal Legislation)

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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High Blood Pressure—an Office Reminder

by Cheryl A. Zaruba

Did you ever stop to think that perhaps a patient's elevated pulse rate may be a result of the type of treatment he or she received from your staff, prior to seeing you? Sound far-fetched? Maybe—however, the possibility does exist and deserves some consideration, because the type of treatment a patient receives from your staff may affect your patient-physician relationship.

The way your staff handles patients both physically and mentally most likely will have an effect on the attitude they hold toward you. And unfortunately, when patients are displeased with the way they are treated, the physician usually is the last person to know.

Many of the irritations patients have concerning office visits can be avoided simply by using common sense and courtesy. Others can be avoided by maintaining a well-trained, competent, supporting staff. For example, if you are behind schedule, an honest statement from your receptionist regarding the length of the delay may help the patient from becoming impatient. (Of course, if apologies for excessive delays are made every day to every patient, it may be indicative of poor scheduling and poor practice management.) Patients should expect no less than thorough, prompt, and efficient responses to inquiries regarding insurance claim forms, payments, and fees.

If your staff is unable to provide them with the information, a concerted effort to refer them to an appropriate person should be made.

Although physicians should have an overall knowledge of the business-related aspects of their practice, they also must be able to rely on office staff to keep abreast of current, efficient, and effective daily office procedures.

In order to maintain a knowledgeable staff, a physician must allow it to take advantage of available education programs on a regular basis, including seminars, conferences, and continuing education programs.

Your medical assistants, including receptionist, secretary, bookkeeper, and clinical assistants, can benefit from several courses sponsored by the OSMA and the Ohio Society Chapter of the American Association of Medical Assistants. The OSMA has been working closely with the Society for over 20 years to help provide continuing education programs for supporting staff.

"The medical assistants associations can be beneficial to physicians only if they encourage their employees to participate in the various programs," said Alford Diller, M.D., a Van Wert family physician. "Our local Association has sponsored several speakers and workshops covering a diverse range of topics, including the psychology of death and dying, Reach For Recovery, prenatal classes, medical law—legal rights of physician and patient, hypertension, medical terminology, and sudden infant death syndrome. Any program or association that helps your personnel become better skilled is worth supporting."

According to ophthalmologist Victor Vermeulen, Columbus, one of the greatest benefits of the Society, in addition to the continuing education programs, is it allows his office staff to associate with others in the same business. He explained that sharing common problems and solutions to them helps make an employee more productive and happier on the job.

In addition to continuing education programs, the American Association of Medical Assistants offers medical assistants the opportunity to become involved in a national certification program.

The certification program includes a general examination and a clinical and administration specialty examination. Content of the examinations includes bookkeeping procedures, oral and written communications, and administrative and clinical procedures.

(continued on page 114)

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¹ Tinkelman, D.G., Carroll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. *Medical Challenge* 10:24-26, 1978.

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INDICATIONS: For relief and/or prevention of bronchospasm associated with bronchial asthma, chronic bronchitis and emphysema.

CONTRAINDICATIONS: Hypersensitivity to any of its components.

WARNINGS: Theophylline should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

arrhythmias may be worsened by theophylline.

Usage in Pregnancy: Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

Theophylline should not be administered concurrently with other xanthines.

Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

ADVERSE REACTIONS: Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. *Gastrointestinal:* nausea, vomiting, epigastric pain, hematemesis, diarrhea. *CNS:* headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. *Cardiovascular:* palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. *Respiratory:* tachypnea. *Renal:* diuresis, albuminuria. *Other:* hyperglycemia, inappropriate ADH

secretion.

Drug Interactions: Toxic synergism with ephedrine and other sympathomimetic bronchodilators may occur.

OVERDOSAGE Treatment:

- If potential oral overdose is established and seizure has not occurred: 1) Induce vomiting 2) Administer a cathartic. 3) Administer activated charcoal.
- If patient is having a seizure: 1) Establish an airway. 2) Administer O₂. 3) Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg. 4) Monitor vital signs, maintain blood pressure and provide adequate hydration.
- Post-seizure coma: 1) Maintain airway and oxygenation. 2) If a result of oral medication, follow above recommendations to prevent absorption of drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube. 3) Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as to not warrant consideration of dialysis.

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Insurance For Life With Tax-Free Dollars

by Douglas J. Freeman

At its meeting on November 10, 1979, the OSMA Council resolved to sponsor a new life insurance plan for members entitled "Retired Lives Reserve." The plan is to be underwritten by PICO Life Insurance Company, a subsidiary of OSMA's Physicians Insurance Company of Ohio (PICO). The following article describes the general features of this new member service.

Physicians have a special need for plans that permit the establishment of financial reserves using tax-deductible dollars during their high-income years.

From the proliferation of plans being offered today by many segments of the financial services industry, one has emerged as the most efficient method of building a personal insurance estate for life. The plan is called Retired Lives Reserve and it is one of the most popular developments in the life of insurance industry in recent years.

PICO Life Insurance Company, subsidiary of Physicians Insurance Company of Ohio (PICO), and the underwriter for the OSMA group term life insurance program, has developed a Retired Lives Reserve plan specifically for OSMA members.

PICO Life's Retired Lives Reserve plan may be provided as an extension of the OSMA group term life plan, or as a separate plan. It is available to groups with less than ten employees as well as to larger groups. PICO Life believes that by offering Retired Lives Reserve on a group-sponsored basis, acquisition costs will be reduced substantially and the savings will be passed on to employers in the form of lower term rates and annual deposit amounts for the funding of postretirement premiums.

As it applies to professional corporations, Retired Lives Reserve provides group term insurance *after* retirement and until death, and is prefunded at retirement through tax-deductible deposits made annually during the working life of the physician. Thus, the physician has a stated amount of life insurance in force at the time of his death, no matter how long he may live, to ensure estate liquidity or family income. The cost of this coverage has been paid with tax-deductible dollars.

Retired Lives Reserve meets the requirements for a plan of group insurance by the Internal Revenue Service. Deposits to the reserve fund, which are made by the corporation on behalf of a physician and other employees, are fully deductible to the corporation and are not included in the employee's income.

Following are the significant tax advantages of Retired Lives Reserve.

1. Employer premiums for preretirement group term life insurance are fully deductible.
2. Employer contributions to a Retired Lives Reserve fund are fully deductible.
3. For insurance amounts over \$50,000, taxable income to active employees is minimal.
4. There is no taxable income to the employee on contributions made to the reserve fund on behalf of the employee.
5. Reserve fund payments for group term life insurance after retirement are not taxable income to the employee, regardless of amount.
6. Earnings on monies in the reserve fund accumulate free of federal income taxes.

A Retired Lives Reserve plan may be designed to fit specific situations. The employer may set the normal retirement age to coordinate with other benefit programs and may set the age at which the corporate contributions cease. The reserve funds will assume premium payments for the retired employee. The employer may include waiver of premiums or accidental death benefits on the preretirement term insurance.

The chart reveals the considerable cost advantages of Retired Lives Reserve over other means of ensuring a substantial postretirement death benefit. This example indicates that a 45-year-old physician may obtain a \$100,000 preretirement and postretirement death benefit for a total cost of \$30,883, compared with \$70,615 for a comparable whole life policy, and \$64,000 for a paid-up-at-age-65 policy.

(Continued)

\$100,000 Coverage

Individual tax bracket-50%; corporate tax bracket-48%.

Physician, age 45, retires at 65, lives to life expectancy (74).

Type of Plan	Total Annual Premiums	Annual RLR Fund Deposit	Total Paid	Net After Tax Deductions
Retired Lives Reserves	45-49 \$ 560	\$ 1,205		
	50-54 \$ 900	1,205		
	55-59 \$ 1,300	1,205		
	60-64 \$ 2,100	1,205		
	<u>\$24,300</u>	<u>\$24,100</u>	\$48,400	\$25,168
Life paid up at age 65	45-64	N/A		
	\$32 per \$1,000 of coverage, or \$3,200 per year			
	20 × \$ 3,200 = \$64,000		\$64,000	\$64,000
Whole life (premiums payable to death)	45-74	N/A		
	\$24.35 per \$1,000 of coverage, or \$2,435 per year			
	29 × \$ 2,435 = \$70,615		\$70,615	\$70,615

NOTE: A. Fund accumulation is based on a nonguaranteed annual interest rate of 8%.

B. Physician is participant in OSMA group term plan, thus annual premium for group term includes 30% dividend credit.

C. IRS requires that an employee must be taxed for employer contribution for pre-retirement insurance provided over \$50,000. Physician would include over the 20-year period, \$11,430 in reported income, with a net outlay of \$5,715 (50%) in taxes.

While no financial services plan is perfect for all situations, Retired Lives Reserve has particularly appro-

priate application to incorporated physicians, as well as to other professional corporations. There is a growing consensus within the life insurance industry that this type of plan, with the continued refinements that ultimately come to all financial services, will be the wave of the future in providing both preretirement and postretirement estate liquidity. Because of its unique advantages, Retired Lives Reserve merits serious consideration today by every incorporated physician.

Additional information about this plan is available from PICO Life.

Douglas J. Freeman is Assistant Vice-President of PICO Life, a subsidiary of OSMA's Physicians Insurance Company of Ohio (PICO).



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MARCH

CURRENT STATUS OF RENAL TRANSPLANTATION: March 6; Community MedCenter Conference Room, Marion; sponsor: Community MedCenter Hospital, Marion; 1 credit hour; guest speaker: James Cerilli, M.D., Professor of Surgery, OSU; no fee; contact: Judith A. Murphy, 1050 Delaware Avenue, Marion 43302, phone: 614/387-0850.

ADVANCES IN UROLOGY: March 6-7; Stouffers Inn On The Square, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106; Phone: 216/444-5696.

FIFTH ANNUAL OB/GYN SYMPOSIUM: March 6-8; Sonesta Beach Hotel & Tennis Club, Key Biscayne, Florida; sponsor: Wright State University School of Medicine, Dept. of Obstetrics and Gynecology; 15 credit hours; fee: \$225 Wright State faculty, \$250 for others; contact: Arlene Polster, Wright State University, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: March 8-15; Caribbean Islands, MTS DANAE of the Costa Line; sponsor: University of Cincinnati College of Medicine, Dept. of Otolaryngology; 24 credit hours; registration fee: \$300; contact: Ms. Robbie Cornelison, University of Cincinnati College of Medicine, Dept. of Otolaryngology, Room 6507, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4155.

OPHTHALMOLOGY SYMPOSIUM: March 10-11; Fawcett Center For Tomorrow, Columbus; sponsor: Ohio State University Center For Continuing Medical Education; 12 credit hours; fee: \$102, \$51 (physicians-in-training); contact: OSU Center For Continuing Medical Education, A-352 Starling Loving Hall, 320 W. Tenth Ave., Columbus 43210, phone: 614/422-4985.

A REFRESHER SEMINAR IN PEDIATRICS FOR PEDIATRICIANS AND FAMILY PHYSICIANS: March 12-13; Hollenden House Hotel, Cleve-

land; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$80, \$40 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

COLONOSCOPY—HOW, WHEN, WHY: March 14-15; Stouffers Inn On The Square; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$200, \$100 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

15th ANNUAL CANCER SYMPOSIUM: March 19, 20; sponsor: Akron City Hospital; 9 credit hours; fee: \$50, \$10 (physicians-in-training and others); contact: Betty VanFleet, Institute of CME, Akron City Hospital, 525 East Market Street, Akron 44309, phone: 216/375-3000.

NEPHROLOGY FOR THE NEPHROLOGIST: March 20-21; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

EVALUATION OF THERAPY METHODS IN THE TREATMENT OF APHASIA: March 24, 25, 26; Stouffers Downtown, Cincinnati; sponsor: University of Cincinnati Medical Center, Division of Audiology and Speech Pathology; 17 credit hours; fee: \$150, \$140 (non-physicians and allied health personnel); contact: Dorothy Air, Ph.D., University of Cincinnati Medical Center, 234 Goodman Street, Pav. A-122, Cincinnati 45267, phone: 513/872-4241.

NUTRITION: FACT OR FICTION IN MY DAILY PRACTICE: March 26; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine, Dept. of Family Practice; 8 credit hours; fee: \$40 Wright State Faculty, \$55 others; contact: Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

(Continued)

HEMATOLOGY UPDATE - 1980: March 26-27; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NUTRITIONAL SUPPORT: March 28-29; Stouffer's Inn on The Square, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

APRIL

CURRENT TOPICS IN MICROBIOLOGY: April 9, 10; Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 (physicians-in-training); contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106, phone: 216/444-5696.

ADVANCES IN DERMATOLOGY: April 21, 22; Bond Court Hotel, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100; contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106, phone: 216/444-5696.

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: April 23, 24; Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$80, \$40 (physicians-in-training); contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106, phone: 216/444-5696.

SPORTS MEDICINE UPDATE: ORGANIZED AND RECREATIONAL RUNNING: April 30; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine; 7 credit hours; fee: \$65, \$50 (WSU faculty), \$35 (athletic directors, coaches and trainers); contact: Arlene L. Polster, Wright State University, Dept. of PMCE; P.O. Box 927, Dayton 45401, phone: 513/372-7140.

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Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting,

gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

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COUNCIL PROCEEDINGS

PROCEEDINGS OF THE COUNCIL

December 15-16, 1979

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 15, and Sunday, December 16, 1979, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; John H. Budd, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; John H. Ackerman, M.D., Columbus; James E. Pohlman, Esq., Columbus; W. J. Lewis, M.D., Dayton.

Those present from the OSMA staff Saturday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Richard A. Ayish, Carol W. Mullinax, David W. Pennington, Eric Burkland.

Those present Sunday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; William Dorner, Jr., M.D., Akron; John H. Budd, M.D., Cleveland; W. J. Lewis, M.D., Dayton.

Those present from the OSMA staff Sunday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, David W. Pennington.

The Council received and acknowledged, with appreciation, a letter of November 28, 1979, from Mrs. Vera L. Kimble, announcing her retirement as of December 31,

and expressing her pride to have been associated with the Association and its members for 22½ years.

The Council expressed appreciation to Messrs. Page and Campbell for the OSMA meeting arrangements for the AMA meeting in Hawaii, and asked that Dr. James H. Sammons, Executive Vice-President of the AMA, be congratulated on the meeting arrangements.

ADMINISTRATION DEPARTMENT

The minutes of the November 10 and 11, 1979 meeting of the Council *were approved*.

The President announced, and the Council ratified, the appointment of the following Ad Hoc Committee to evaluate OSMA House of Delegates voting procedures: James B. Daley, M.D., Cleveland; Richard L. Fulton, M.D., Columbus; A. Burton Payne, M.D., Ironton.

The subject of Council reports to the House of Delegates was discussed.

The Council voted to provide brief and concise reports on selected issues to the House of Delegates on an experimental basis.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Dr. Barr presented the Cash Report as of November 30, 1979.

The minutes of the December 14, 1979 meeting of the Committee on Auditing and Appropriations were presented by Dr. Williams and *were approved*.

The 1980 budget was then presented.

After comprehensive review of the financial print-outs and budgetary items therein, the 1980 budget *was approved*.

Mrs. Wisse was complimented on the electronic data processed financial system now in service.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Emergency and Disaster Medical Care

Mr. Ayish presented the minutes of the December 1, 1979 meeting of the Committee on Emergency and Disaster Medical Care.

He discussed a state legislative proposal concerning emergency medicine for the information of the Council.

Committee on Education

Ms. Dodson presented the minutes of the December 13, 1979 meeting of the Committee on Education.

The Council *approved* the establishment of an appeals mechanism for organizations, hospitals and other agencies with regard to accreditation procedures.

The minutes, as a whole, *were approved*.

Education Programs

The Council discussed Practice Productivity Programs for 1980 and *approved* them, with a request that the Association be reimbursed for executive and administrative services.

GOVERNMENT MEDICAL CARE DEPARTMENT

Health Planning Update

Mr. Pennington presented an update on health planning in Ohio.

Committee on Government Medical Care Programs

The minutes of the December 5, 1979 meeting of the Committee on Government Medical Care Programs were presented by Mr. Gillen.

He reviewed the Committee's comments on a draft copy of "*National Guidelines for Health Planning*."

A letter of December 3, 1979, from President Morgan to the Board of Directors of the Health Resources Administration commenting on the guidelines was discussed by the Council.

The communication *was approved* with a minor amendment.

With regard to the minutes, a section on "Medicaid — Adequacy of Physician Records" was amended to provide that the claim forms contain "date of service," "service provided," and "diagnosis," to justify reimbursement.

The Medicaid-Obesity Control section of the minutes was referred back to the Committee on Government Medical Care Programs for more concise definitions.

Committee on Cost Effectiveness

Dr. Pfahl presented the minutes of the December 14, 1979 meeting of the Committee on Cost Effectiveness.

The Council reaffirmed its commitment to the Committee's efforts as a high priority staff function and to the support of the voluntary effort.

DEPARTMENT OF ORGANIZATION SERVICES

Report on AMA Interim Session

Dr. Clarke reported on the Hawaii Interim Session of the AMA.

Dr. Clarke indicated that Reference Committee F, of which he is a member, will consider matters of medical ethics and the report of the Council on Long Range Planning and Development at the Annual AMA meeting in June.

He announced that memorial resolutions to Drs. Robechek and Petznick were presented by the delegation and were adopted.

Drs. Lewis and Budd were recognized for reviews of the AMA meeting.

It was announced that Dr. Frank H. Mayfield, Past OSMA President from Cincinnati, received the AMA Distinguished Service Award, by vote of the House of Delegates. The award will be presented at the July, 1980 meeting in San Francisco.

Dr. Clarke discussed the electoral process for positions on AMA Councils and Committees. An ad hoc committee of the Delegation for study of candidates was authorized.

A request for support of the candidacy of Dr. Lawrence McCormack, Cleveland, for the Council on Medical Service was considered by the Council and *was approved*.

Ad Hoc Committee to Review House of Delegates Policy

Mr. Campbell presented a progress report on the work of the Ad Hoc Committee to Review House of Delegates Policy.

Physicians Life Insurance Company of Ohio

Dr. Gaughan reported on the progress of Physicians Life Insurance Company of Ohio and described innovative policies being developed by the company for the benefit of the policyholders.

Professionals Insurance Company

Dr. Abromowitz reported on the progress of Professionals Insurance Company, a subsidiary of PICO.

PICO

Dr. Thomas reported on the progress of Physicians Insurance Company of Ohio.

DEPARTMENT OF HEALTH EDUCATION

Sports Medicine

Mr. Clinger presented a letter from Dr. Leonard Rome, President, Ohio Chapter, American Academy of Pediatrics, regarding the OSMA recommendations concerning physical examinations of junior and senior high school athletes and the record keeping involved.

Bus Driver Exams

The Council considered a request from the Department of Education to restart the Committee for Bus Driver Physical Examinations.

The Council authorized such a committee as an advisory group to the Department.

OHIO STATE MEDICAL ASSOCIATION

	01	02	03	04
	Admin.	CME	Health Ed.	Field Serv.
Salaries	\$ 78,700.00	\$ 97,350.00	\$ 62,980.00	\$43,150.00
Staff Expense	10,000.00	6,000.00	3,553.00	4,500.00
Pres. Exp.	8,000.00	0	0	0
Pres. Elect	4,100.00	0	0	0
Past Pres.	2,000.00	0	0	0
Council Expense	43,000.00	0	0	0
AMA Del/Alt. Exp.	0	0	0	0
AMA-ERF	0	0	1,015.00	0
Committees	350.00	9,000.00	15,612.00	200.00
Annual Meeting	0	112,126.00	0	0
Building Expense	7,344.00	4,486.50	2,200.50	1,857.50
Car Lease	31,700.00	350.00	300.00	3,000.00
Council Dist. Conf.	8,200.00	0	0	0
Data Processing	0	0	0	3,000.00
Emergency Fund	2,300.00	0	2,000.00	0
Equipment Lease & Supply	1,912.50	4,281.25	2,912.50	1,812.50
Field Service	0	0	0	0
Insurance & Bonding	17,950.00	1,000.00	650.00	650.00
Interest	1,600.00	1,600.00	850.00	650.00
Journal Publ. Cost	0	0	0	0
Legal Expense	50,000.00	0	0	0
Library	450.00	300.00	350.00	700.00
Meeting Expense	0	0	1,500.00	4,000.00
Officer Honorariums	19,000.00	0	0	0
OSMAgram	0	0	0	0
Pension Expense	0	0	0	0
Postage	1,400.00	3,900.00	1,100.00	1,000.00
Prof. Relations Acct.	1,000.00	750.00	750.00	750.00
Public Relations	0	0	0	0
Supplies: Misc.	600.00	1,000.00	400.00	500.00
Supplies: Office & Printing	2,300.00	4,400.00	900.00	1,000.00
Taxes: Payroll	4,000.00	5,300.00	3,100.00	3,000.00
Telephone & Telegraph	7,300.00	4,100.00	2,800.00	3,000.00
Depreciation	4,624.00	2,929.00	1,573.00	1,295.00
Furniture & Equip.	4,000.00	275.00	0	0
Mortgage Amort.	5,000.00	3,200.00	1,600.00	1,400.00
TOTALS	<u>\$314,830.50</u>	<u>\$263,347.75</u>	<u>\$106,146.50</u>	<u>\$75,265.00</u>

1980 BUDGET: DEPARTMENT ANALYSIS

05 Fiscal Mbrshp.	06 Govt. Rel.	07 Commun.	08 Org. Serv.	09 State-Fedl. Leg.	Rental Area	1980 Budget
\$132,390.00	\$ 89,500.00	\$ 99,160.00	\$ 72,820.00	\$129,680.00	0	\$ 805,730.00
8,000.00	12,000.00	4,700.00	4,000.00	38,000.00	0	90,753.00
0	0	0	0	0	0	8,000.00
0	0	0	0	0	0	4,100.00
0	0	0	0	0	0	2,000.00
0	0	0	0	0	0	43,000.00
0	0	0	47,110.00	0	0	47,110.00
0	0	0	0	0	0	1,015.00
14,000.00	8,820.00	300.00	850.00	5,050.00	0	70,594.00
0	0	0	0	0	0	112,126.00
57,887.00	2,672.00	6,458.00	4,408.50	7,286.00	0	94,600.00
300.00	3,000.00	600.00	300.00	450.00	0	40,000.00
0	0	0	0	0	0	8,200.00
68,850.00	0	0	0	6,000.00	0	77,850.00
2,300.00	6,500.00	7,000.00	500.00	1,170.00	0	20,600.00
14,562.50	2,168.75	4,837.50	3,725.00	3,787.50	0	40,000.00
0	0	0	0	0	0	0
650.00	650.00	1,300.00	650.00	1,650.00	0	25,150.00
2,000.00	1,000.00	1,750.00	1,500.00	2,050.00	0	13,000.00
0	0	163,335.05	0	0	0	163,335.05
0	0	0	0	0	0	50,000.00
200.00	1,100.00	875.00	100.00	1,050.00	0	5,125.00
0	0	4,250.00	0	0	0	9,750.00
0	0	0	0	0	0	19,000.00
0	0	12,000.00	0	0	0	12,000.00
80,000.00	0	0	0	0	0	80,000.00
7,500.00	3,000.00	9,100.00	1,900.00	3,100.00	0	32,000.00
750.00	750.00	1,500.00	750.00	1,500.00	0	8,500.00
0	0	37,700.00	0	0	0	37,700.00
2,000.00	650.00	1,300.00	800.00	1,250.00	0	8,500.00
8,100.00	1,300.00	8,084.49	1,500.00	13,350.00	0	40,934.49
4,400.00	5,000.00	7,600.00	4,500.00	8,700.00	0	45,600.00
5,000.00	3,100.00	6,200.00	3,000.00	6,600.00	0	41,100.00
22,702.00	1,912.00	3,768.00	2,968.00	3,529.00	0	45,300.00
40,300.00	450.00	836.30	2,420.00	1,500.00	0	49,781.30
5,400.00	2,000.00	4,200.00	3,100.00	4,450.00	0	30,350.00
<u>\$477,291.50</u>	<u>\$145,572.75</u>	<u>\$386,854.34</u>	<u>\$156,901.50</u>	<u>\$238,982.50</u>	<u>0</u>	<u>\$2,165,192.34</u>

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

The Federal legislative update was presented by Mr. Mulgrew.

He reported on medicine's victory in the cost containment issue with the defeat of President Carter's legislation for mandatory controls.

He asked for support of Senate Bill 1991, which would provide for restrictions on the Federal Trade Commission.

State Legislation

Mr. Mulgrew discussed the passage of S.B. 271, which provides for the return of most of the Stabilization Reserve Fund contributions to Ohio physicians and hospitals and eliminated the \$250 yearly contribution from physicians assessed at the time of malpractice premium payment.

Mr. Ayish discussed other state legislative proposals:

S.B. 311, to include physicians' offices under certificate of need.

H.B. 879, stringent informed consent procedures for abortion.

H.B. 938, establish loans for medical students.

Dr. Ford reported on the November 14, 1979 meeting of the State Legislative Committee and on the organizational progress of the "key man" project and the cooperative program with the Ohio specialty societies.

The Council commended the Committee on Legislation and the Department staff.

COMMUNICATIONS DEPARTMENT

Ms. Mullinax reported on *Synergy*.

Ms. Doll reported on the electronics media program.

Dr. Diller presented minutes of the Ad Hoc Committee on "Letters to the Editor and Editorial Policy," which met November 11, 1979.

The following statement *was approved* by the Council:

"All evidence (membership and readership surveys, discussions with physicians, study of journals from other states) indicates that physicians do not look to their state journal for scientific information. At the same time, there is a growing interest in socioeconomic information, especially that which pertains to Ohio. Therefore, the committee recommends that the scientific section of the OSMA Journal be de-emphasized. The Committee recommends that scientific articles in the Journal be reduced to no more than one or two per issue during that time period. Attempts will be made to ascertain member reaction to this change (further membership and readership surveys). A survey on OSMA communications activities, which will accompany the

January OSMAgram, should be of some assistance in this regard."

DEPARTMENT OF FIELD SERVICE

Mr. Holcomb presented the report of the Department of Field Service.

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

LEGAL COUNSEL REPORT

The Legal Counsel report was presented by Mr. Pohlman.

The mandatory nonbinding arbitration feature of H.B. 682 was discussed and referred to the OSMA Task Force on Professional Liability for study and report on January 26, 1980.

A request for legal assistance was referred to the Ad Hoc Committee on Legal Assistance.

DIRECTOR OF HEALTH

Dr. John Ackerman, Ohio Director of Health, addressed the Council.

He discussed legislative proposals regarding industrial diagnostic and treatment radiologic device registration and safety measures.

ATTEST: Hart F. Page, CAE
Executive Director

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Annual Meeting

1980		MAY				1980	
S	M	T	W	T	F	S	
				1	2	3	
				8	9	10	
4	5	6	7	15	16	17	
11	12	13	14	22	23	24	
18	19	20	21	28	29	30	31
25	26	27	28	29	30	31	

"A week to remember"

Delegates' Report AMA Interim Meeting

by Oscar W. Clarke, M.D., Chairman, and
Thomas W. Morgan, M.D., Co-Chairman, Ohio Delegation AMA

The following is a report of the important issues voted on by the Ohio AMA Delegation during the AMA Interim Meeting in Honolulu.—ED.

The Ohio Delegation to the AMA introduced two Memorial Resolutions in honor of:

1. George W. Petznick, M.D., Cleveland, deceased September 8, 1979 and
2. P. John Robechek, M.D., Cleveland, deceased September 10, 1979.

There were several items of business which were felt to be of interest and following is a report on those issues:

1. PRINCIPLES OF MEDICAL ETHICS

The AMA House of Delegates voted to file a progress report and refer a resolution to the Ad Hoc Committee on the Principles of Medical Ethics on the above subject. The progress report on the activities of the Ad Hoc Committee on the Principles of Medical Ethics was presented, which stated that the final report will be presented at the 1980 Annual Meeting of the AMA House of Delegates. Final action cannot occur before the Interim Meeting, December 1980.

The Ohio Delegation vote was unanimous in support of this action.

2. MEDICARE REGULATIONS

The AMA House of Delegates voted to adopt the following substitute resolution:

RESOLVED, That the AMA express its opposition to retroactive denials of payment for appropriately rendered services by Medicare and other third-party payors for necessary preoperative evaluations and procedures contractually covered by the payors.

The Ohio Delegation vote was unanimous in support of this action.

3. NATIONAL HEALTH INSURANCE AND CATASTROPHIC HEALTH INSURANCE PROPOSALS

The AMA House of Delegates voted to adopt the

following substitute resolution:

RESOLVED, That the AMA continue to advocate in a positive manner the superiority of a voluntary, fee-choice method of medical and health delivery compared to a system dominated and controlled by the federal government.

The AMA House of Delegates also reaffirmed the resolution they adopted last December, and referred it to the board with authority to cause to be introduced in Congress a draft health insurance bill "only if necessary." That resolution embodies four principles:

1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and coinsurance.
2. A simple system of uniform benefits provided by the federal, state, and local governments for those individuals who are unfortunate enough (through no fault of their own, ie, age, disability, financial hardship, etc.) not to be able to provide for their own medical care.
3. A nationwide program by the private insurance industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.
4. A program developed pursuant to those principles should be administered at the state level with national standardization through federal guidelines.

The Ohio Delegation vote was unanimous in support of this action.

4. FEDERAL TRADE COMMISSION

The AMA House of Delegates voted to adopt a resolution, refer a resolution to the Board of Trustees and adopt two Board of Trustees reports on the above subject.

(Continued)



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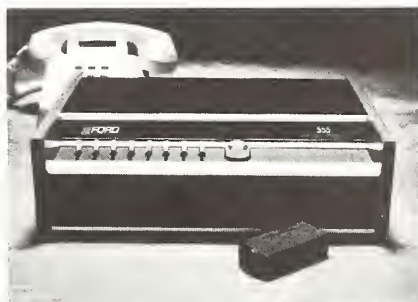
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304/527-1671

The adopted resolution commended the AMA leadership for past and ongoing actions on behalf of patients and physicians throughout the United States to combat the arbitrary, overzealous, and self-defeating regulations of the Federal Trade Commission. The referred resolution contained the following resolves:

RESOLVED, That the House of Delegates commend the Board of Trustees and the executive staff for voicing the support of the American Medical Association for the McClure-Melcher amendment; and be it further

RESOLVED That the American Medical Association, through its constituent, component, and affiliated medical societies actively support and work for enactment of legislation which would stipulate that the FTC lacks jurisdiction over sovereign state and nonprofit organizations, such as professional associations, and which also would clarify that the FTC is not to intrude into areas which learned societies traditionally have assumed leadership and responsibility for professional self-regulation in the interest of the public.

One adopted Board of Trustees report recommends approval of the following:

RESOLVED, That the AMA continue to oppose restrictive proposals that curtail communication or effective participation on the part of the medical profession with the governing boards of health care plans.

The second adopted Board of Trustees report recommended approval of the following:

RESOLVED, That the House of Delegates request the Board of Trustees to closely monitor the activities of the Federal Trade Commission as they relate to health care and the medical profession and to initiate and support remedial legislation where advisable.

The Ohio Delegation vote was unanimous in support of this action.

5. FUTURE DIRECTIONS FOR MEDICAL EDUCATION

The AMA House of Delegates voted to adopt an amended Council on Medical Education report that contains a series of recommendations on preparation for medical education, admission to medical school, generalism and specialism in medical education, and the AMA's role in medical education, social responsibilities of schools of medicine, medical specialty boards, universities and university hospitals, U.S. citizens seeking medical education abroad, licensure, evaluation of medical students and physicians, and accreditation.

The Ohio Delegation vote was unanimous in support of this action.

6. FOREIGN MEDICAL GRADUATE AFFAIRS

The AMA House of Delegates voted to adopt an amended Board of Trustees report on the above subject. Portions of the report were referred to the Board of Trustees. The recommendations in the report dealt with:

1. Need for participation and membership in organized medicine.
2. U.S. citizens and foreign medical schools.
3. Implications of Title VI of PL 94-484 for International Educational Exchange.
4. Foreign Medical Graduates without ECFMG Certification or Licenses.
5. Foreign Medical Graduates, American Specialty Boards, and State Licensing Boards.

The Ohio Delegation vote was unanimous in support of this action.

7. CONTINUING MEDICAL EDUCATION ACCREDITATION

The AMA House of Delegates voted to adopt a report of the Council on Medical Education on the above subject.

The Council on Medical Education report specifically recommends that the House of Delegates continue its direction of the accreditation of organizations providing continuing medical education including the recognition of state medical societies to accredit on behalf of the AMA organizations providing intrastate continuing medical education.

The Council on Medical Education has reviewed the regulations of state licensing bodies that require accredited continuing medical education and finds that in general, state medical societies, specialty societies, and the AMA are recognized as accrediting agencies.

The Ohio Delegation vote was unanimous in support of this action.

8. JCAH STANDARDS FOR CATEGORIZATION OF HOSPITAL EMERGENCY SERVICES

The AMA House of Delegates voted to adopt a report from the Board of Trustees on the above subject.

The report contained the following statement:

The Standards-Survey Procedures Committee of JCAH, in November 1979, thoroughly reviewed the subject of categorization and specifically the concerns of the AMA House of Delegates. Although the Committee did not make any specific recommendations to the JCAH Board of Commissioners, it did direct JCAH staff to continue to monitor the field experience of the application of the Standard. Further, it instructed staff to consult with the appropriate organizations representing those specialties designated in Level I categorization and report to the Committee at its next meeting. The Board of Trustees, through the AMA Commissioners, will continue to convey the concerns of

the House of Delegates and to evaluate the appropriateness of emergency services categorization as part of the accreditation process. A progress report on these developments will be presented to the House of Delegates at the 1980 Annual Meeting.

The Ohio Delegation vote was unanimous in support of this action.

9. HOSPITAL EMERGENCY SERVICE CATEGORIZATION

The AMA House of Delegates voted to refer to the Board of Trustees a resolution on the above subject. The resolution addresses the categorization of emergency services as defined by the Joint Commission on Accreditation of Hospitals with particular concern over its requirements for Category I services. The resolution seeks to abolish the requirements for 24-hour in-hospital coverage in designated specialties and asks that physicians who are neither board eligible nor certified and physicians in training not be considered for purposes of categorizations. The report also requests the AHA to adopt a similar policy and that the JCAH amend its standards accordingly.

The Ohio Delegation voted 8-1 in support of the action taken by the AMA House of Delegates.

10. HILL-BURTON REGULATION

The AMA House of Delegates voted to adopt a substitute resolution on the above subject.

RESOLVED, That the American Medical Association oppose the recent attempts by the United States Department of Health and Human Services, the Massachusetts Department of Public Health and certain hospital boards of trustees to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act and to shift responsibility for these requirements to hospital medical staffs and believes that a hospital's Hill-Burton Act obligations should be satisfied in a manner which does not interfere, or interferes in the least restrictive manner, with the professional rights of its medical staff; and be it further

RESOLVED, That the American Medical Association continue to challenge these regulations, and support the efforts of the American Hospital Association in its litigation to eliminate the promulgation of such regulations by the United States Department of Health and Human Services; and be it further

RESOLVED, That the American Medical Association continue to endorse and explore means of assuring equal access to medical care for the people of the United States of America.

The Ohio Delegation vote was unanimous in support of this action.

11. UNIFORM BRAIN DEATH ACT

The AMA House of Delegates voted to adopt a

Board of Trustees report on the above subject. The report recommended that the AMA model bill as amended be adopted as AMA policy.

The text of the model bill is as follows:

To Provide for Determination of Death

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, shall be considered dead. A determination of death shall be made in accordance with accepted medical standards.

Section 2. A physician or any other person authorized by law to determine death who makes such determination in accordance with Section 1 is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination.

Section 3. Any person who acts in good faith in reliance on a determination of death is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

Section 4. If any provision of this Act is held by a court to be invalid such invalidity shall not affect the remaining provisions of the Act, and to this end the provisions of this Act are hereby declared to be severable.

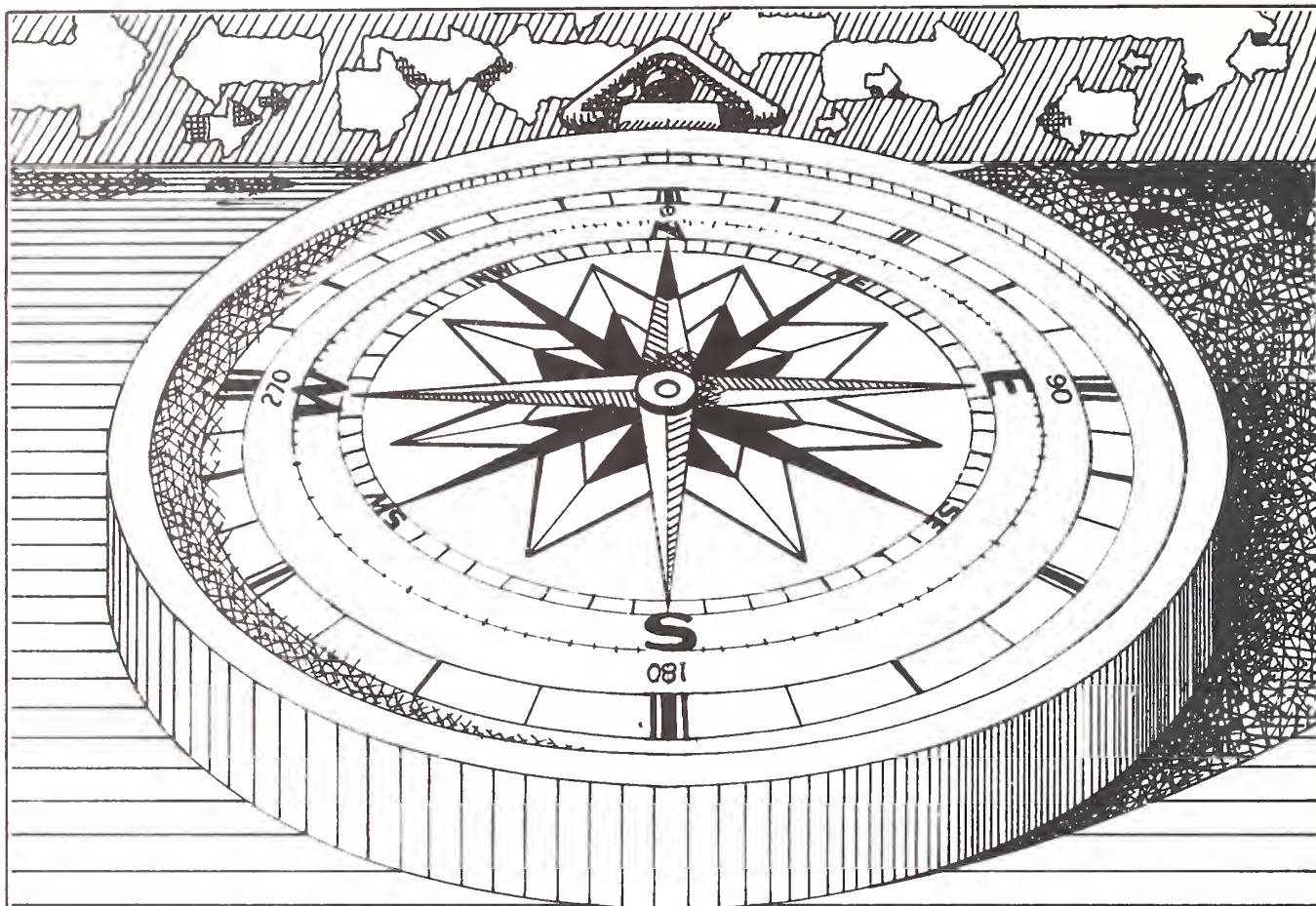
The Ohio Delegation vote was unanimous in support of this action.

12. IMPACT OF LEGAL ADVICE ON AMA POLICY-MAKING DECISIONS

The AMA House of Delegates voted to refer to the Board of Trustees a resolution and suggested amendments on the above subject. The Board of Trustees, after consultation with state medical societies, specialty societies, and other component medical societies will report back to the House of Delegates at the Annual Meeting in Chicago, July 1980.

The Ohio Delegation vote was unanimous in support of this action.

The nation's infant mortality rate in 1978 was 13.6 per 1,000 live births, the lowest annual rate ever recorded in this country and 3.5% lower than the rate for 1977. The average life expectancy is now 73.2 years, an increase of about three years in the last decade.



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Tennis Elbow Syndrome: Results of the "Lateral Release" Procedure

Marc J. Rosen, M.D.
F. Paul Duffy, M.D.
Edward H. Miller, M.D.
Edward J. Kremchek, M.D.

Lateral epicondylitis, better known as tennis elbow, has been the subject of much discussion in both the medical literature and the lay press. A variety of therapeutic modalities, surgical and nonoperative, have been described. While this disorder usually is self-limited, the patient may be disabled for an extended period of time. When nonoperative treatment fails to provide relief, any number of surgical procedures can be relied upon to provide resolution of symptoms. We have found surgical release of the common origin of the radial extensors, as originally described by Bosworth,¹ to be highly effective and simple to perform. Hospitalization is brief and the return of function is rapid. Our findings suggest that surgical intervention should be considered earlier in the course of the disease if nonoperative therapy has failed to provide relief.

LATERAL EPICONDYLITIS of the elbow has become known to both the physician and the general public as tennis elbow. The syndrome has several other synonyms.² The term "tennis elbow" first was used in the literature around 1900,³ and the first clinical description of it appeared in 1873.⁴ It was a case of a writer with lateral elbow pain, reported in a German publication. Curiously, the first game of lawn tennis was played in Wales that same year.

Many activities can be causative; few of the people who suffer from the syndrome are engaged in the sport of tennis. The disorder is more commonly found in carpenters, dentists, heavy laborers, and surgeons as well as a variety of other occupations. Activities such as turning a doorknob or a screwdriver may be responsible for aggravating the condition. Politicians who shake too many hands also are prone to this ailment.⁵

The growing popularity of tennis, however, has reinforced the association of this sport and the syndrome of lateral epicondylitis in the public mind. The lay press contains many advertisements for tennis elbow braces, suggestions for those who suffer from this syndrome, and a recent issue of *Consumers Report* has detailed both the

indications for surgery and the types of surgical procedures now available. So familiar is the public with the syndrome that it often is the topic of conversation at middle-class and upper-middle-class cocktail parties where the sufferers compare their regimens of treatment and share the advice of their respective physicians.

Diagnosis

The diagnosis of the syndrome seldom is in doubt. Characteristically, the patient complains of pain over the lateral aspect of the elbow increasing with extension of the wrist or supination against resistance with the elbow held in extension. Pain also may increase with gripping an object firmly and, in advanced cases, holding a teacup may be painful. Palpation of the elbow reveals point tenderness over the common origin of the radial extensors. X-ray films are of little diagnostic importance, but occasionally calcific deposits may be noted adjacent to the lateral epicondyle of the humerus. The medial epicondyle may be similarly involved, however, this is a far less common condition.

Most patients suffering from the syndrome have never played tennis. Among those who do play tennis, however, several studies have shown that approximately 47% to 50% of the people who play regularly will be subject to developing lateral epicondylitis at some time.⁶

Treatment

The first line of treatment is avoidance of the aggravating activity. This is not particularly an easy form of treatment when the patient's lateral epicondylitis developed because of activity required in his occupation. There are a variety of nonoperative methods of treatment including the use of a tennis elbow brace, oral anti-inflammatory agents, physical therapy, and/or local injections of the painful area with steroid preparations and local anesthetics, as well as splinting or casting.^{7,8}

Alterations of equipment have been found to be helpful for tennis players who suffer from the condition. The use of a lightweight, flexible racquet with larger

grip size has been shown to be beneficial.⁹ Alterations in the production of the tennis stroke, particularly the backhand, have been shown to significantly decrease the degree of symptomatology as well as to prevent the development of the syndrome.⁷⁻⁹

In general, it can be said that over 90% of the patients who present with a history of lateral elbow pain and findings typical of lateral epicondylitis will obtain relief by one of the nonoperative methods mentioned.¹⁰⁻¹² However, even with successful employment of nonoperative modalities, the length of disability may be prolonged. Patients frequently suffer from this syndrome for many months before relief is obtained by nonoperative means only to have it recur with resumption of the inciting activity.

Pathology

There is no general agreement within the literature as to the responsible pathologic lesion. The more popular theories are:² (1) minute tears in the conjoined tendon of the extensor muscle origin at the lateral humeral epicondyle; (2) periostitis resulting from a partial tear of the origin at the extensor carpi radialis brevis; (3) a radiohumeral bursitis in a bursa proposed to lie beneath the conjoined tendon of the extensor origin; (4) compression of the radial head in pronation and supination by the annular ligament; (5) traumatic synovitis of a radiohumeral hinge-blocking motion of the radiohumeral joint; and (6) neuritis of the posterior interosseous nerve. In a review of the literature, Cyriax was able to identify

at least 29 different pathologic lesions which have been associated with the tennis elbow syndrome.³

Surgical Treatment

While there is no well-defined pathologic state associated with lateral epicondylitis, several authors have shown that when nonoperative therapy fails, surgical treatment usually is highly successful.^{1,10-13} A variety of surgical procedures have been described. In 1955, Bosworth described four different operations for relief of lateral epicondylitis, all of which produced favorable results.¹ The first of these procedures involved a transverse division of the common extensor origin; the second involved the transverse division of the extensor origin with removal of a synovial fringe from the radiohumeral joint; the third was transverse division of the extensor origin and resection of a portion of the orbicular (annular) ligament; the fourth, a vertical incision in line with the fibers of the extensor origin, resection of the orbicular ligament, and repair of the defect in the common origin. Bosworth abandoned the first of these procedures when he accidentally incised the annular ligament during one of these operations.^{1,10} It appeared to him that the results obtained by this procedure were superior to those of the preceding operations.

Since that time, several other procedures have been described for treatment of this syndrome all of which basically stem from the work of Bosworth. They represent modifications of his operation or employ the technic described by Garden in which he lengthened the tendon of the extensor carpi radialis brevis.¹³

Spencer and Herndon again noted the efficacy of Bosworth's original procedure in their paper.¹⁴ Our current study confirms the theory that this original operation provides a rapid return to normal function of the extremity, relief of pain, short disability, and no significant loss of range of motion or of strength. It is a very simple surgical procedure requiring brief hospitalization, minimal operative time, and can be performed under local anesthesia if necessary.

Surgical Technic

The procedure usually is performed under tourniquet control and general anesthesia. A straight incision, 5 cm to 6 cm in length, is made over the lateral aspect of the elbow. Sharp dissection is carried down to the extensor aponeurosis. It is important to have access to the full width of the extensor origin, in order to release all the fibers attached to the lateral epicondyle. The extensor aponeurosis then is cleanly divided and elevated from its origin on the lateral epicondyle, and the extensor mass is allowed to retract distally about one half to three fourths of an inch. Every attempt is made to remain extraarticular to the radiohumeral joint. The subcutaneous tissue and skin are closed and an occlusive dressing applied. No postoperative splint or sling is employed. Active range of motion of the operated limb is begun on

Dr. Rosen, Cincinnati, Senior Resident in Orthopedic Surgery, University of Cincinnati College of Medicine.

Dr. Duffy, Cincinnati, Director, Section of Orthopedic Surgery, Our Lady of Mercy Hospital; Chairman, Section of Fractures & Orthopedics, Good Samaritan Hospital; Attending Staff, Children's Hospital; Courtesy Staffs, Bethesda, Deaconess, and Christ Hospitals; and Assistant Clinical Professor of Surgery, Orthopedics, University of Cincinnati College of Medicine.

Dr. Miller, Cincinnati, Director of Orthopedic Surgery, Christian R. Holmes, Cincinnati General, and Veterans Administration Hospitals, and Children's Hospital Medical Center; Chief Clinician, Ambulatory Patient Care, University of Cincinnati Medical Center; Consultant in Orthopedic Surgery, The Shriners Hospital; Courtesy Staffs, Brown County General Hospital, Georgetown; and Christ Hospital, Cincinnati; and Professor of Orthopedic Surgery, University of Cincinnati College of Medicine.

Dr. Kremchek, Cincinnati, Attending Staffs, Good Samaritan and Our Lady of Mercy Hospitals; Courtesy Staffs, Bethesda, Christ, Deaconess, and Clermont County Hospitals; Director, Good Samaritan Hospital Orthopedic Outpatient Clinic; and Assistant Clinical Professor Orthopedic Surgery, University of Cincinnati College of Medicine.

Submitted June 7, 1979.

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the first postoperative day, and the patient may be discharged on the first or second day thereafter.

Materials and Methods

Fifty patients were treated between 1970 and 1978, using this surgical procedure. Twenty-one patients were available for follow-up examinations and each was examined by one of the authors. We were able to contact nine other patients who could not appear for follow-up examination, and they responded by completing a questionnaire. The group of patients evaluated consisted of 12 women and 18 men. These patients' ages ranged from 18 years to 64 years, average age 49 years. Symptoms were present in the nondominant extremity in seven patients who appeared for examination and in 14 patients, the dominant upper extremity was involved.

In all patients, both those examined and contacted by questionnaire, the elapsed time from surgery ranged from 6 months to 102 months (8½ years) with an average of 39 months. The patients who were contacted and appeared for examination were questioned regarding time lost from work and duration of symptoms prior to surgery. Records were made as to whether or not they were privately insured or covered under some form of workers' compensation. In the group of patients examined, only two were covered under a workers' compensation claim. Patients also were questioned as to preoperative treatment. Description of subjective results from surgery, eg, pain, range of motion, strength, and overall function in activities of daily living, was requested. They were asked to rate these postsurgical parameters as no change, improved, much improved, or the same as the unoperated limb. The patients who felt there was no change postoperatively were identified as poor results, and those who improved were considered fair results. Patients who were much improved or whose operated extremity was felt by them to be the same as the unoperated extremity were graded as good or excellent results, respectively.

All were tested for grip strength, strength of active wrist extension with elbow held in full extension, as well as strength of active flexion. The range of motion of the operated and unoperated extremities was compared. Elbow flexion and extension were recorded as well as pronation and supination of the forearm. Patients who could not appear for examination were contacted by letter and asked to report their subjective results based on the same parameters.

Results

The duration of symptoms prior to surgery ranged from 3 months to 60 months (five years) with an average of 16 months. Postoperatively, the time lost from work ranged from 1 week to 16 weeks with an average of 4.6 weeks. It was noted that the patient who remained off work for 16 weeks was one of those patients covered under industrial compensation. A prolonged time to return to work was not evident in the second patient who

was covered by workers' compensation. Preoperative treatment for 24 patients consisted of at least one injection of a steroid preparation and local anesthetic. Two patients were treated preoperatively with some form of a sling or brace. Fourteen patients received outpatient physical therapy. Eight patients were treated with oral medication ranging from muscle relaxants and analgesics to anti-inflammatory agents including aspirin. Of the 21 patients, six displayed tenderness at the operative site. This was very minor and in no case was the tenderness sufficient to inhibit function of the operative limb in any case.

The operated and unoperated limbs were compared for grip strength. No loss of strength was noted in the operated side. Strength of active extension was tested with a fixed, spring-loaded scale measuring from zero to 15 pounds of longitudinal force. Due to the inaccuracy of measurements above 15 pounds of force, we considered these results to be statistically insignificant. The strength of active flexion, likewise, was insignificantly different.

Active range of elbow flexion was unaltered. The range of elbow extension was found to be unchanged when compared to the unoperated arm. However, the average elbow extension in the operated limbs was +2.1 degrees, whereas the average extension was +3.7 degrees in the unoperated limbs. It seemed, generally, that patients who had a moderate degree of elbow hyperextension in their unoperated elbow didn't regain this motion after surgery. Range of motion in pronation and supination of the forearm was the same in the operated and nonoperated sides. There also was no difference in the range of active wrist flexion. The range of motion of active wrist extension in the operated limbs was measured from 45 degrees to 90 degrees. In the unoperated limbs, motion ranged from 60 degrees to 90 degrees. An average of 64.73 degrees of active extension was found in the operated side, whereas extension averaged 70.94 degrees in the unoperated side.

Patients contacted by questionnaire as well as those patients personally examined by the authors were asked to describe any postoperative pain they had experienced. Eighteen patients rated their operated limb the same as the unoperated one; 11 said their pain was much improved. One patient described the pain as being improved but still present, and no change was noted postoperatively by one patient. When further questioned as to the range of motion of their operated elbows, 20 patients rated it the same as their unoperated elbow. Eight reported their range of motion was much improved. One man considered his range of motion to be improved, but another noted no change. Similar results were noted in the categories of strength and overall functional level.

Two complications were encountered in the entire series of 50 patients in the period from 1970 to 1978. A superficial wound infection developed in one patient which was resolved with treatment of oral antibiotics. No residual symptoms were present at the last examination.

(Continued)

ation. One patient developed a synovial fistula which responded to immobilization. Results for patients whose operated elbows were the same as the unoperated side or were much improved over their preoperative state were rated as excellent and good results, respectively. Those who felt that they were slightly improved were considered fair results, and those in whom there was no change noted from their preoperative state were considered poor results. In a follow-up of this study, 90% of the patients were in the excellent and good categories. Five percent were considered fair and 5% were in the poor category. It is important to note that the patient whose pain, strength, and overall function reportedly were not changed from their preoperative level was the patient who developed the synovial sinus postoperatively. These results are consistent with those reported by Posch in his series of lateral release operations.¹⁵ The great number of patients interviewed personally by the authors were unhappy with the length of preoperative symptoms and conservative treatment. Generally, their comments suggested that the pain was prolonged by delaying surgery.

Conclusion

Our experience with the lateral release operation for epicondylitis of the elbow provided several conclusions: (1) There was good to excellent relief of pain. (2) Generally, there was a minimal loss of active wrist extension in the operated limb although over 90% of the patients noted no subjective difference in range of motion. (3) No difference in grip strength could be discerned comparing the operated and unoperated limbs. The mild loss of elbow hyperextension in the operated extremity does not appear to be significant; those patients in whom a loss of hyperextension of the elbow was present had no complaint of weakness, pain, or of alteration in range of motion. Over 90% of our patients were found to have good or excellent results by our criteria. As noted before, they returned to work in an average of 4.6 weeks. The one disturbing figure in our findings was the duration of symptoms prior to surgery which averaged 16 months. It would appear that the efficacy of nonoperative therapy should be determined at an earlier date and months of morbidity avoided.

Summary

While a variety of operations are available for the relief of this symptom complex, Bosworth's original lateral release requires minimal surgical manipulation of the elbow and provides generally favorable results. Patients are able to return to occupational and recreational activities early and rapidly regain full use of the operated extremity with prompt resolution of pain. We have found the lateral release operation to be an effective method for surgical treatment of this disorder. There appears to be no advantage to more extensive operations which violate the radiohumeral joint and annular ligament. We reemphasize the need for earlier surgical intervention in patients who are disabled by the symptoms of lateral epicondylitis.

References

1. Bosworth DM: Surgical treatment of tennis elbow: A follow-up study. *J Bone Joint Surg* 47-A:1533-1536, 1965.
2. Friedlander HL, Reid RL, Cape RF: Tennis elbow. *Clin Orthop* 51:109-116, 1967.
3. Cyriax JH: The pathology and treatment of tennis elbow. *J Bone Joint Surg* 18:921-940, 1936.
4. Runge F: Zur Genese und Behandlung des Schreibeframpfes. *Berliner Klinische Wochenschrift* 10:245, 1873.
5. Management of tennis elbow. *Med Lett Drugs Ther* 19:33-34, April 22, 1977.
6. Priest JD: Tennis elbow: The syndrome and a study of average players. *Minn Med* 59:367-371, 1976.
7. Nirschl RP: Tennis elbow. *Orthop Clin North Am* 4:787-800, 1973.
8. Nirschl RP: Tennis elbow. *Primary Care* 4:367-382, 1977.
9. Bernhang AM, Dehner W, Fogarty C: Tennis elbow. A biomechanical approach. *J Sports Med* 2:235-260, 1974.
10. Bosworth DM: The role of the orbicular ligament in tennis elbow. *J Bone Joint Surg* 37-A:527-534, 1955.
11. Coonrad RW, Hooper WR: Tennis elbow: Its course, natural history, conservative and surgical management. *J Bone Joint Surg* 55-A:1177-1182, 1973.
12. Boyd HB, McLeod AC Jr: Tennis elbow. *J Bone Surg* 55-A:1183-1187, 1973.
13. Garden RS: Tennis elbow. *J Bone Joint Surg* 43-B:100-106, 1961.
14. Spencer GE Jr, Herndon CH: Surgical treatment of epicondylitis. *J Bone Joint Surg* 35-A:421-424, 1953.
15. Posch: Transactions AAOS, 1978. ☆☆☆

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Rooms will be held until 6 PM unless payment is guaranteed.

In recognition of his contributions to Emergency Medicine residency programs, **JAMES W. AGNA, M.D.**, Cincinnati, received an award from the Society of Teachers of Emergency Medicine.

During its 45th Annual Scientific Assembly, the American College of Chest Physicians conferred Fellowship in the Academy on the following OSMA members: **JOHN E. ALBERS, M.D.**, Cincinnati, **EDMUNDO M. ANTEOLA, M.D.**, Lakewood, **RAIS A. BEG, M.D.**, Cleveland, **SURENDRA N. DASH, M.D.**, Canton, **JOSEPH A. GOLISH, M.D.**, Cleveland, **FREDERICK A. HEUPLER, M.D.**, Cleveland, **T. J. MAXIMIN, M.D.**, Rocky River, **RAJENDRA A. PATEL, M.D.**, Xenia, **PETER M. SANFELIPPO, M.D.**, Columbus, **HANS H. J. ZWART, M.D.**, Dayton.

Marymount Hospital in Cleveland awarded several OSMA members with plaques in recognition of their 30 years of service.

ANGELA ADAMS, M.D., **ROBERT BARTUNEK, M.D.**, **ANTONIO BROGLIO, M.D.**, **IRVING CRAMER, M.D.**, **WILFRID GILL, M.D.**, **PATRICK HEALEY, M.D.**, **VICTOR IPPOLITO, M.D.**, **LEONARD KLEINMAN, M.D.**, **WILLIAM KUBICEK, M.D.**, **THOMAS MANNING, M.D.**, **NICHOLAS MISISCHIA, M.D.**, **V. JERRY PICHA, M.D.**, **P. JOHN ROBECHKE, M.D.** (deceased), **PAUL SUHAY, M.D.**, **CHARLES WILLIS, M.D.**, **FREDRICK ROEMER, M.D.**, **EDWARD SHANNON, M.D.**, Cleveland, **FRANCIS BUDD, M.D.**, Berea, **ANTHONY DINDIA, M.D.**, Cleveland Heights, **JOHN HINDULAK, M.D.**, Deerfield, **FERDINAND HRUBY, M.D.**, Chagrin Falls, **VINCENT KAVAL, M.D.**, Aurora, **BERNARD MALASKY, M.D.**, Parma, **SYLVESTER MISSAL, M.D.**, Cleveland Heights, **ANTHONY PERKO, M.D.**, Northfield.

Two OSMA past presidents, **GEORGE N. BATES, M.D.**, Toledo and **OSCAR W. CLARKE, M.D.**, Gallipolis, served on AMA reference committees during the interim meeting in Hawaii.

DANIEL J. BIRMINGHAM, M.D., Belmont, was inducted into the Fellowship of the American College of Surgery.

THOMAS E. FOX, M.D., Mason, was presented with the annual Dr. Daniel Drake Award for 1979, at the annual dinner meeting of the Southwestern Ohio Society of Family Physicians held at the Cincinnati Academy of Medicine on November 27th.

The SOSFP consists of several hundred physicians in family practice in eight southwestern Ohio counties. This award, the tenth to date, is given annually to a physician because of past accomplishments.

Dr. Fox previously was honored with the Rardin Award last year in Columbus by the Ohio Academy of Family Practice as outstanding family physician of the year in the State of Ohio.

Outgoing President of SOSFP is Jack Thinnis, M.D., and incoming President is Lucy Oxley, M.D., both of Cincinnati.

CHARLES A. GERACE, JR., M.D., Columbus, was inducted as a Fellow in the American College of Surgeons.

JACK GRUBER, M.D., Dayton, was elected to membership in the Central Association of Obstetricians and Gynecologists.

BENJAMIN C. HUMPHREY, M.D., Franklin, was appointed to the Wagnalls Memorial Board of Trustees.

ALAN R. KAMEN, M.D., Canton, was installed as President of the Aultum Hospital Medical Staff. **V. T. MEHTA, M.D.**, was elected president-elect and **ROBERT B. MILLER, M.D.**, Canton, secretary-treasurer.

DRS. ANTHONY H. LEE, Alliance, **C. GLOSH LODI**, Medina, and **VERNE H. DODSON**, Miamisburg, were certified as Diplomates of the American Board of Family Practice.

(Continued on page 116)

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Notice From State Medical Board Regarding Physician Licensure

It has become apparent that some confusion may exist as to licensure status of some individuals during the current renewal processing. The confusion may be compounded by recent newspaper stories which indicate that approximately 8,000 physicians are currently practicing without a license. Those stories do not fairly reflect the interim status of licensees during renewal processing.

In fact, those physicians who have made timely and good faith application to the Board prior to January 1, 1980 are protected by Ohio law and **are not illegally practicing even though they may not yet have received a wallet identification card.** Section 119.06, Ohio Revised Code, provides in pertinent part as follows:

"When periodic registration of licenses or renewal of licenses is required by law, a licensee

who has filed his application for registration or renewal **within the time and in the manner provided by statute or rule of the agency**, shall not be required to discontinue a licensed business or profession merely because of the failure of the agency to act on his application. Action of an agency rejecting any such application shall not be effective prior to **fifteen days after notice of the rejection is mailed to the licensee.**"

In other words, a physician who has mailed his renewal card, a properly completed CME log, and check for \$50 to the Board prior to January 1, 1980, would remain licensed until 15 days after a notice of noncompliance was mailed to him by the Board.

/s/ Ray Q. Bumgarner
Chief Counsel and
Assistant to the Administrator

(Continued)

DEADLINE

OSMA NOMINATIONS AND RESOLUTIONS

OSMA members are reminded that the deadline is approaching for submission of resolutions to be considered at the 1980 Annual Meeting. Such resolutions must be submitted no later than *March 12, 1980*. By this date, all nominations for the office of president-elect of the OSMA also must have been submitted.

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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NEWS

Starting Your Practice

A two-day program sponsored by the OSMA and AMA, designed for young physicians planning to enter private practice and physicians who have been in practice less than one year, will be held on March 5 and 6, 1980.

The "Starting Your Practice" workshops will provide attendees with answers to many important questions:

How much is it going to cost me to get started?

Should I buy, rent, or build office space?

Where and how do I get office help?

What are some of the legal problems?

What is the best accounting and bookkeeping system for my practice?

The workshop is limited to 30 participants. The registration fee is \$105 for OSMA or AMA members and \$115 for nonmembers. Spouses are invited to attend as auditors at a charge of \$20 to cover lunches and breaks. To register contact OSMA-Department of CME, (614) 228-6971.

OSMA Membership Increases

After showing strong gains every year during the past decade, membership in the Ohio State Medical Association reached an all-time high of more than 12,000 in 1979.

"This gain is of special significance since it is a tangible indication of active support from Ohio physicians for a vigorous Association which has a fine record for leadership and accomplishment," said Dr. Thomas W. Morgan, Association President.

(Story continued from page 83)

The certification program and education programs, which are sponsored and/or supported by the OSMA, the Ohio Society Chapter of the AAMA, and the national AAMA, are examples of the methods physicians can use to raise patient-care standards.

These programs can be successful only if they receive the continued support of Ohio physicians. As long as the Society maintains its high standards and professionalism, the AMA and OSMA will continue to support the programs and goals of the Association. A well-trained and competent supporting staff is an essential component of a successful medical practice.

For further information regarding the Medical Assistants Society, contact your local chapter of the Medical Assistants Association or Ellen Young, AAMA—OSS President, 903 Rogers Street, Toledo, Ohio 46305. If your county does not have an organized chapter, write to Nena LaBarbera, Component Society Consultant, 51 Marlin-dale, Youngstown, Ohio 44512.



OSMA past president *Robert S. Martin, M.D.*, Zanesville, died after a prolonged illness this past December. He served as OSMA president during 1957 to 1958. He was a Councilor for the eighth district for many years. He also was a past member of the Ohio Delegations to the American Medical Association House of Delegates.

Dr. Martin received his MD degree from the University of Cincinnati in 1919.

He was President of the Muskingum County Medical Society and a member of the Board of Governors of the American College of Surgeons. He was President of the Rotary Club of Zanesville and served for 13 years on the Board of Directors of the First National Bank of Zanesville. For many years he served on the Board of Directors of Ohio Medical Indemnity Company and the Board of the Medical Indemnity of America.

Dr. Martin exemplified the true physician, the patriotic citizen, humanitarian, community leader, and a faithful and proud family man. He is survived by his wife, Rachel Cowden Martin of Zanesville, and daughter, Mrs. Rachel Bess Geiger of Cincinnati.

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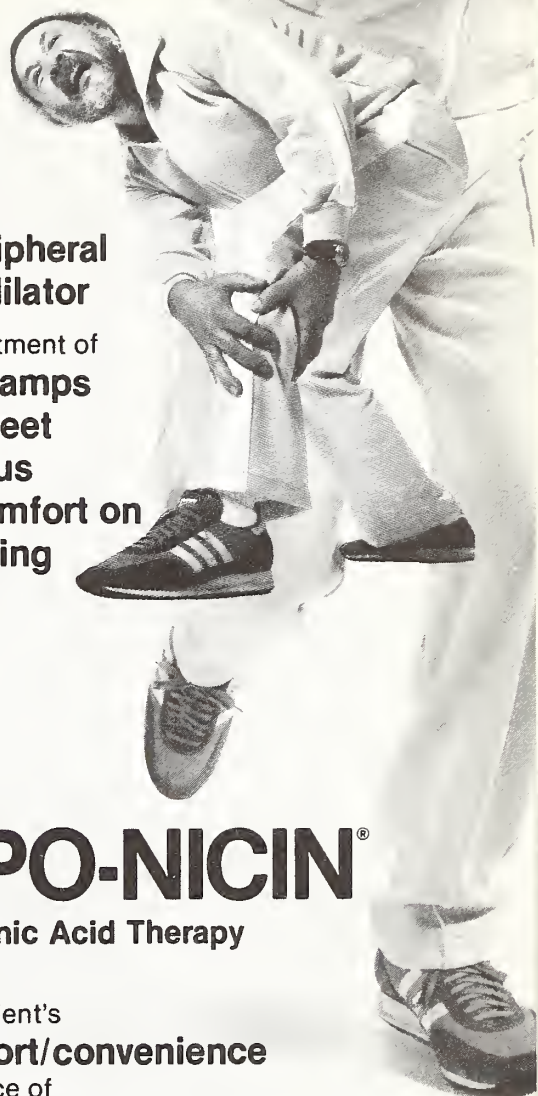
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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

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Pyridoxine HCL (B-6) 10 mg.

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Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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The DeMoss Report Congress: Above the Law?

They can dish it out but they can't take it. Perhaps that's what we should say about members of Congress. Did you know that not one of the regulatory laws passed by Congress since 1935, including the Civil Rights Acts of 1964 and minimum wage legislation applies to the operation of Congress itself?

That's the way congressmen want it, at least the majority of them. Congressional offices are exempt from occupational health and safety administration regulations.

Some OSHA people say most congressional offices are such firetraps that they would be shut down if judged on the same basis as private industry.

Women staffers on Capitol Hill earn barely one-half the median salary of their male counterparts. Blacks fill only 3% of top-level jobs. Congress has adopted strict laws outlawing conflicts of interest in the executive branch, but has watered down its own ethics code to permit many such conflicts. Lawmakers have exempted themselves from paying income taxes in the District of Columbia, Maryland and Virginia since 1977.

One bright note: the Supreme Court has ruled that former Representative Otto Passman of Louisiana unjustly fired a staffer, Shirley Davis, because he felt it was essential for his number two aide "to be a man."

Perhaps more such court cases and an enraged public will cause some more cracks in what has become known as "the last plantation."

Reprinted Courtesy WCMH-TV, Columbus



OSMA Golf Tournament

Westbrook Country Club, Mansfield, is the location of the 1980 Ohio State Medical Golfers Association (OSMGA) tournament on Friday, June 13.

Preregistration forms and other vital information will be mailed to OSMGA members in mid-April. The registration fee, which includes greens fee, luncheon, banquet, locker room tips, and prizes, is charged for the annual tournament. Tournament capacity will be 150 players—on a first come, first served preregistration basis. OSMGA President is C. J. Shames, M.D., of Mansfield.

Physicians wishing to join OSMGA should write to: OSMGA, 600 South High Street, Columbus, Ohio 43215. There is no membership fee.

COLLEAGUES

LAWRENCE LANGSAM, M.D., Chesterland, assumed the position of chairman of the department of surgery at Fairview General Hospital.

STEVEN H. LICHTBLAU, M.D., Columbus, was named medical director of First Community Village. **DRS. ROBERT J. MURPHY** and **PAUL J. KEITH** were named associate medical directors.

WILLIAM J. MEYER, M.D., Toledo, was installed as President of the Toledo Area Council, Boy Scouts of America.

BENJAMIN SCHUSTER, M.D., Dayton, was elected Governor for the State of Ohio for the Scientific Council of the American College of Angiology for 1979 to 1980.

OSMA member **BRUCE STEWART, M.D.**, Moreland Hills, was elected chairman of the division of surgery at the Cleveland Clinic Foundation.

JAMES UNGERLEIDER, M.D., Dayton, was re-elected President of Hospice of Dayton, Inc.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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SCIENTIFIC EXHIBITS WANTED

1980 OHIO STATE MEDICAL ASSOCIATION ANNUAL MEETING

Do you have a scientific exhibit or know of one which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1980 OSMA Annual Meeting. The eligibility is as follows: Scientific Exhibits will be limited to those presentations developed by members of the OSMA. Exceptions will be considered by the Exhibit Screening Chairman if any exhibit is deemed to be of special interest or educational benefit to members of the OSMA. The latter shall not be eligible for any awards or ranking by the OSMA, but shall be designated as of "special merit."

Exhibit Space will be limited this year and booth assignment will be made on first come, first serve basis.

Exhibits will be set up and viewed on the second floor at the Cincinnati Convention Center, 200 West Fifth Street, Cincinnati, Ohio 45202. The Exhibit days and times will be as follows: Monday, May 12 - 9:00 a.m.-4:00 p.m.; Tuesday, May 13 - 9:00 a.m.-4:00 p.m.; Wednesday, May 14 - 9:00 a.m.-4:00 p.m.

REQUEST FOR SCIENTIFIC EXHIBIT APPLICATION

1980 Annual Meeting, Ohio State Medical Association

Cincinnati Convention Center, Cincinnati, Ohio, May 12, 13, & 14

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JOHN JACOB DEJAK, M.D., Cleveland; Creighton University School of Medicine in Omaha, 1941; age 63; died December 4, 1979; member OSMA and AMA.

ARMANDO GARZA, M.D., Bloomville; University of Medicine, Nacional Autonoma de Mexico, Mexico; 1954; age 52; died November 29; member OSMA and AMA.

JOSEPH P. HARVEY, M.D., Youngstown; University of Pittsburgh School of Medicine, 1918; age 87; died November 23; member OSMA and AMA.

PAUL R. MINICH, M.D., Greenfield; University of Cincinnati College of Medicine, 1921; age 87; died December 8; member OSMA and AMA.

BENJAMIN P. PERSKY, M.D., Cleveland; University of Michigan Medical School, 1925; age 80; died November 9; member OSMA and AMA.

DALE EDWIN ROTH, M.D., Newark; The Ohio State University College of Medicine, 1929; age 74; died December 14; member OSMA and AMA.

ALPHONSE R. VONDERAHE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1921; age 83; died December 17; member OSMA and AMA.

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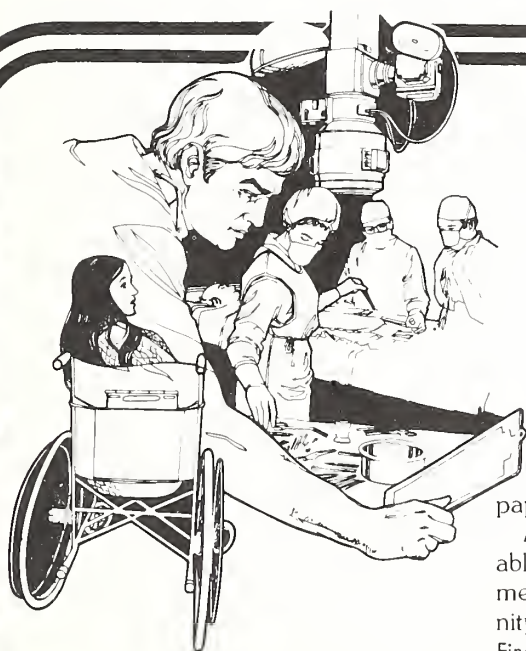
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New Journal Policy Guidelines

In an attempt to improve communications with the members of the Association, immediate past president John J. Gaughan, M.D., appointed an Ad Hoc Committee of Council last April to study the policies of the OSMA Journal. Specifically, the Committee was charged with studying available information, such as the Journal Readership Survey and the OSMA Membership Survey, to determine if the content of the Journal was responsive to member needs and interests. The goal of the Committee was to increase member access to the Journal and to encourage member feedback and involvement in the editorial content. The Committee, chaired by Alford C. Diller, M.D., Councilor from the third district, met several times during the past year and submitted the following observations to Council:

The Committee noted that individual member access to the content of the Journal was minimal and gained only through acceptance of a scientific article or by specific invitation of the managing editor. The Journal contained no designated Letters to the Editor column, no member opinion columns, and generally afforded the members little input into their own publication. After studying both the Journal Readership and Membership Surveys, the Committee found that the least read section of the Journal was the scientific articles section. Further, the Surveys indicated that members were extremely interested in the current socioeconomic and legislative issues facing medicine today. Based on the Surveys and additional information which was submitted to the Com-

mittee, the Committee made the following recommendations which were approved by Council:

1. That the Journal devote more time and space to developing articles which reflect the interests of the members as indicated on the two Surveys and any subsequent surveys.
2. That the scientific portion of the Journal be de-emphasized and that the Journal print no more than one or two scientific articles per month.
3. That a President's Page be implemented to allow the President to communicate directly with the members on issues of concern to the Association.
4. That individual members be encouraged to submit articles on current socioeconomic issues facing medicine today.
5. That the Journal attempt to develop a column of Opinion and Debate whereby two members would debate opposing sides of a single issue.
6. That the Federal and State Legislative columns be reinstated.
7. That a subcommittee of Council serve as an Editorial Board to screen all articles pertaining to the above and that it serve in an advisory capacity to the Journal when necessary.

Several of the recommendations have been implemented, specifically, the President's Page and reinstatement of the Legislative columns. The Council encourages members to submit their ideas, opinions, and suggestions regarding Journal editorial content to the OSMA Department of Communications.

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To assure prompt delivery, when replying to an advertisement over a **Journal** box number, address letters as follows: Box (insert number), c/o **The Ohio State Medical Journal**, 600 South High Street, Columbus, Ohio 43215.

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STATE

Physicians' Assistant Bill in Senate

The Senate Education and Health Committee began proponent hearings on Sub. H.B. 16 (J. Thompson, D-Cleveland) on February 20. H.B. 16 is the Physician's Assistant Bill that passed the House of Representatives in June of last year. Supporting testimony was offered by physicians' assistants and physicians' assistant education program staff members. The Ohio Hospital Association testified in support of the bill, claiming the right to employ any licensed or certified category of health manpower. Current law requires a physician's assistant be employed by a physician. The proposed changes in Sub. H.B. 16 would enable **hospitals or other facilities** to hire physicians' assistants, although physicians would continue to provide supervision. Committee members questioned the potential cost of the proposals and the current educational requirements for physician's assistant certification. Opponent testimony will be heard this month. The Ohio State Medical Association opposes the provision of H.B. 16 which permits institutions to employ physicians' assistants directly, and supports a requirement for the immediate "physical supervision" of the physicians assistants' activities by a physician.

Con Dispute Sends Home Health Care Licensing Bill Back To Subcommittee

H.B. 554, the Home Health Care Licensing Bill, has been referred back to subcommittee of the Senate Education and Health Committee following the failure of a compromise concerning Certificate of Need (CON). The bill, which earlier underwent several weeks of hearings in subcommittee, would establish standards for licensure of home health care agencies in Ohio. An OSMA-supported amendment was adopted in subcommittee to require that the patient's personal physician or another physician, if approved by the patient, supervise all medical diagnosis and treatment.

As initially reported by the subcommittee, the bill provided that the establishment of new home health care services or facilities must be reported by

the agency. However, the formal CON process and the necessity of CON approval was not mandated.

This compromise was opposed in full committee by representatives of nonprofit and public home health care agencies, health commissioners, and Health System Agency directors who insisted that new agencies must be placed under CON in order to assure wide distribution of services and avoid an excess of agencies in urban areas. Nonprofit and public agencies need not be licensed to receive public third-party reimbursement.

Representatives of organizations interested in establishing new proprietary agencies, which must be licensed to receive public third-party reimbursement, oppose CON as a mechanism which restrains the expansion of services at a time when new services are needed.

Senator Marcus Roberto (D-Ravenna) has indicated that the CON issue must be resolved by subcommittee before consideration by the full committee.

Revisions Proposed for Nurses

A revision of the Nurse Practice Act containing a proposed redefinition of the practice of nursing has been introduced by Rep. Ed Orlett (D-Dayton). H.B. 1029, promoted by the Ohio Nurses Association, proposes to discontinue the issuance of interim permits and includes a number of administrative changes in the operation of the State Board of Nursing.

The existing definition of the practice of nursing contains a specific prohibition against "acts of medical diagnosis or prescription of medical, therapeutic or corrective medical measure by a nurse." The proposed definition in H.B. 1029 is both expansive and vague. The proposed definition states the practice of nursing is: "The exercise of judgment in the application of scientific knowledge with the focus of providing care to and coordinating care for individuals, families and communities, both ill and well, with the goal of attaining, maintaining and restoring optimal health."

H.B. 1029 will require the State Board of Nursing to "exercise general supervision over nursing practice including the investigation of alleged violations in all settings where nursing is practiced."

The OSMA has great concern with the expanded definition of nursing and the interpretive and investigative powers which would be granted to the State Board of Nursing. H.B. 1029 has been referred to the House Health and Retirement Committee. Hearings are expected to begin this month.

Physicians should contact their local legislators

to inform them of the proposed expanded definition of the practice of nursing that will not specifically prohibit nurses from "acts of medical diagnosis or prescription of medical, therapeutic or corrective medical measures."

FEDERAL

Senate Reins In FTC

The Senate has finally reined in the Federal Trade Commission (FTC).

On February 7, the Senate approved a new FTC authorization, S. 1991, by a 77-to-13 margin. An even more important vote on S. 1991 came on February 6, on an amendment by Senators Harrison Schmitt (R-N.M.) and Sam Nunn (D-Ga.). This amendment would have allowed either House of Congress to study and then veto proposed FTC rules, the same one-house legislative veto language adopted by the House last session. The Senate rejected the amendment by a 44-to-53 vote.

On an 87-to-10 vote, the Senate did adopt a weaker two-house congressional veto provision proposed by Michigan Democrat Carl Levin. The Levin amendment gives the House and Senate up to 80 days to disapprove a proposed agency rule. The President could, however, overrule Congress' veto. In the past, the Senate has refused to endorse any congressional veto of FTC rules. Last month's vote at least acknowledges that the agency's regulations pose some problems, and that Congress ought to be able to kill them before they do any damage.

The Senate failed to include the OSMA-supported McClure amendment by a 45-to-47 vote. That amendment would have limited the FTC's power to investigate the activities of the medical and legal professions already regulated by state law. Both Ohio Senators voted against the amendment. Senator Metzenbaum was a champion of the FTC throughout the debate and argued vigorously against limiting the agency's powers.

The FTC authorization now goes to conference, where House and Senate negotiators will hammer out a compromise. The House seems determined to get nothing less than a one-house legislative veto, but there is a chance the Senate will acquiesce.

If there is an impasse, the FTC will have to operate under a stopgap funding resolution.

Don't leave this important issue to chance. Write your Representative. Urge that he or she accept nothing less in the final FTC authorization than the true congressional veto provision the House voted last November.

National Health Insurance (NHI)

Senator Edward Kennedy's health care concept is the most comprehensive and costly of all proposals. The Massachusetts Democrat's comprehensive, full-coverage NHI proposal (S. 1720, H.R. 5191) carries a price tag of \$40 to \$60 billion a year. Two thirds of the money would come from tax revenues and one third from employer-paid premiums.

President Carter's approach is phased-in NHI coverage, initially less comprehensive and expensive than the Kennedy proposal. The Administration's bills (S. 1812, H.R. 5400) would cost \$24 billion annually, with \$18 billion coming from the treasury and the rest from employers.

Catastrophic Coverage

The Senate Finance Committee probably will resume marking up Chairman Russell Long's catastrophic coverage proposal later this month. The Louisiana Democrat's unnumbered bill would require employers to provide private catastrophic insurance for their employees. It would cover all medical bills exceeding \$3500 annually and all hospital stays exceeding 60 days. The cost to employers is estimated at \$10 billion a year.

Competition Approach

Rep. Ullman and Senators David Durenberger (R-Minn.) and Richard Schweiker (R-Pa.) have introduced "pro-competition" bills, H.R. 5740, S. 1968 and S. 1590, respectively. These bills would amend the tax code in ways which should make the health care industry more competitive — requiring employers to offer several health care options, including low- and high-cost plans. Employer contributions to each option would be identical. Employees choosing an option costing less than their employer's contribution would get a cash rebate. Employers not offering at least three choices or whose premiums exceed a federally set maximum would not be allowed to deduct their contributions from their taxes.

House Republicans' Alternative

The Medical Expense Protection Act (H.R. 6405), introduced this week by House Minority Leader John Rhodes of Arizona for his GOP colleagues, is a combination of features in the Ullman, Durenberger and Schweiker bills. In addition, it provides for catastrophic coverage of those not covered by private insurance and unable to qualify for Medicare. The trigger point for this federally paid coverage would depend on income. For example, a family making \$16,000 a year would have to pay its first \$2400 in medical bills before government help started. H.R. 6405's price tag is estimated at \$7 billion annually.

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COVER: This month's cover won Outstanding Entry in the 1979 Journal Photographic Exhibit. Earl R. Haynes, M.D., Zanesville, photographed this scene entitled, "Children of Mykonos" using a Leica M3 camera, Leica Summicron lens at an aperture of f:5.6 at 1/60. Film: Kodachrom II. He processed and printed the photo.

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The Membership Obstacle Course

The greatest milestone in our membership history was reached last month when the OSMA membership rose above 12,000 for the first time ever. This gain signifies the dedicated support of Ohio physicians for their county and state societies. We are proud of these efforts to gain strength through unity — but we cannot stop here.

Although organized medicine has gained steady support at the county and state levels over the past ten years, the AMA has not been as fortunate. Here is where we now must turn our efforts to increase membership.

Most of us can remember when virtually every physician held membership in all the component societies of the AMA. The few who did not usually were viewed with disdain by their peers.

A look at some of the sweeping changes that have taken place in our society during the last quarter century goes a long way toward explaining the steady decline in AMA membership which now presents one of the most vexing problems facing the AMA Federation.

AMA membership primarily is dependent upon the efficiency of county and state societies in recruiting new members and also upon the members of the Federation encouraging their colleagues to join.

Until the past few weeks medical society membership was considered a prerequisite to hospital staff appointment. The "requirement" alone assured the AMA few worries regarding membership. Moreover, there were very few professional societies competing for membership dollars, since not many physicians could meet the stringent membership requirements. Then, too, the medical profession had to contend with very few sharply divisive issues which have multiplied geometrically as government has increasingly sought to influence and control the practice of medicine. But those were the "good old days." A quick glimpse of recent developments provides a sobering contrast.

Drastic changes in the legal and regulatory atmosphere surrounding professional organizations, the proliferation of specialty societies which have largely usurped the AMA's educational function, and the inevitable disenchantment of physicians who find their own political and socioeconomic views on medical issues frequently at

odds with AMA policy, have combined to create a formidable negative effect on our membership statistics. And on the economic front, dues requirements have soared to unheard-of heights largely because of the escalation of legal and administrative expenses necessitated by our defense against civil and governmental court actions.

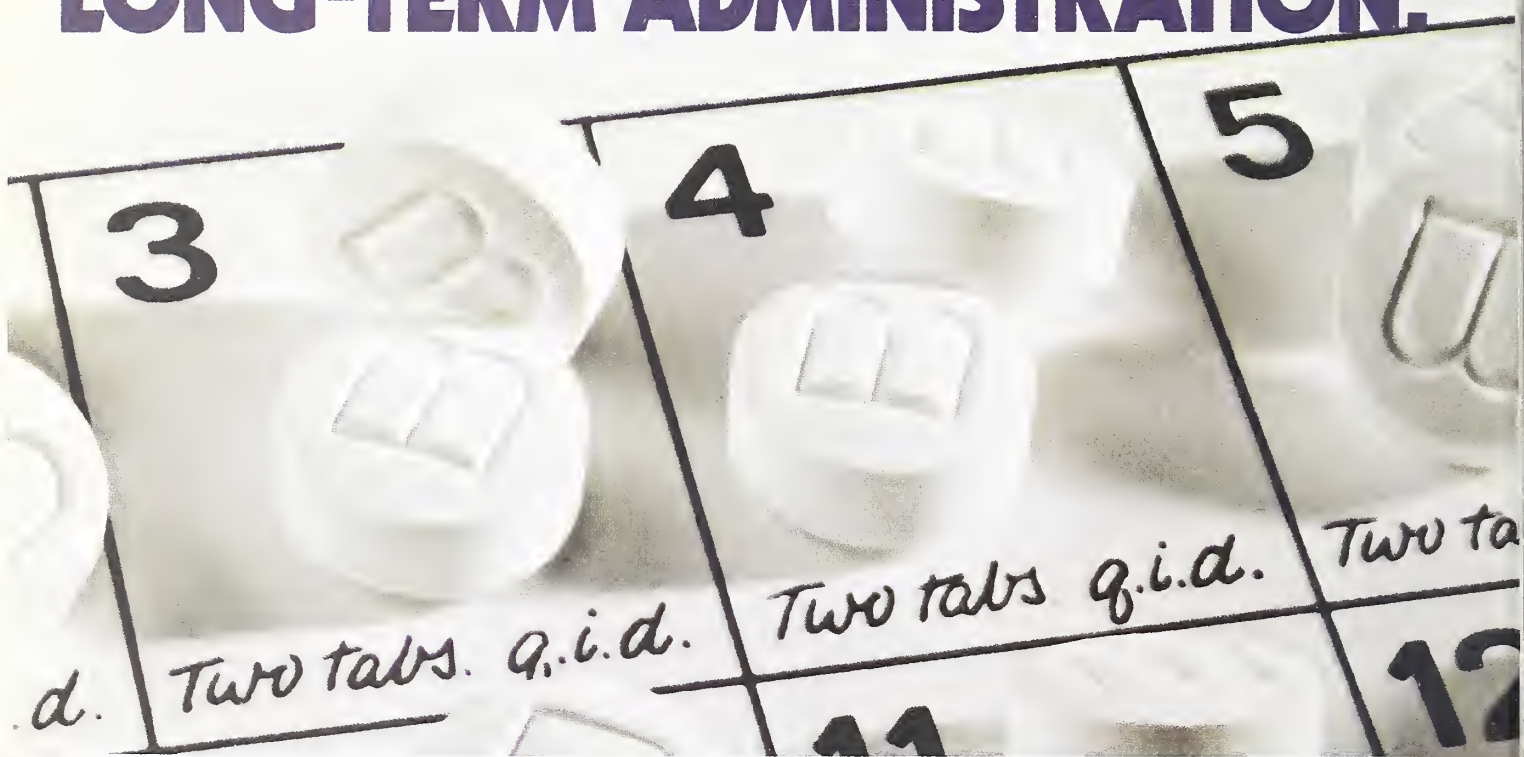
Doing business at the same old stand is no longer tolerable as far as membership recruitment is concerned. Admittedly, there is no quick solution to the AMA's complex problems. A great deal of time may be required to address these particular issues in an effective way.

But there is one area that cries out for immediate attention primarily from the county medical societies. I refer to the unnecessary barriers to medical society membership which have remained in place since bygone days when the societies could afford ridiculous impediments such as prolonged waiting periods for processing applications (6 months to 2 years), probationary membership requirements (associate membership for at least one year), cumbersome application requirements, and, even worse, lack of a recruitment program. (A recent AMA survey showed that nearly half the state and county societies had no recruiting program at all.)

Increased attention to the concerns of members, better membership services, carefully conducted membership surveys to identify major concerns, and better responsiveness to the needs of members are consistently cited as measures which will reverse the membership decline. But the plain fact is that even if all of these laudable goals are achieved, membership would still pose a sizable problem, because the busy physician likely will not feel it worthwhile to waste his or her time negotiating obstacles which should long since have been eliminated, particularly when there is no longer a perceived "requirement" either socially or professionally to be a medical society member. I do not mean to imply that simply removing impediments will solve our membership problems, but it is certainly the easiest deficiency to correct. I urge all county societies to review their membership procedures and to streamline them where indicated.

What it finally comes down to is this: In the old days, medical societies had a seller's market. Now, it is a buyer's market and the sooner we realize it the better!

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To the Editor.— I enjoyed reading your article in the December 1979 issue of the OSMA Journal concerning *The Free Riders*. I certainly agree that we must do everything possible to increase membership in the AMA. Although the three recommendations by the AMA's (CLRTD) Committees were interesting, they did not really address the two problems. Apparently they have not made any attempt to determine why people either drop out or refuse to join the AMA. I think that the present structure of having the local medical society bill for membership at a county, state, and national level is still the best way to assure maximum membership in the AMA.

It is my feeling that many members either drop out of the AMA or don't join because they feel they have no voice in the policy decisions and operation of the national organization. There are also many members that are beginning to feel the same way about the state organization.

I think that the best way to get members interested in the state and national organization and make them feel that they are a part of the operation is to give them back the vote. By the vote I mean that officers for the state and national organizations should be elected by ballot of the general membership and not elected by the House of Delegates. Until we do this I feel we will have further drop-outs and declining membership.

/s/John H. Boyles, Jr., M.D.
Dayton, Ohio

To the Editor.— As a certified pediatric nurse associate, I must take issue with several statements made in the clinical and scientific editorial "Physicians and Nurses: Two Kinds of Practitioners," by Gertrude Torres, R.N., Ed.D., which appeared in *The Ohio State Medical Journal* in January, 1980.

The term "practitioner" was given to medicine and nursing by Henry K. Silver (not Silva) and Loretta C. Ford, R.N., Ed.D., when they developed the first Pediatric Nurse Practitioner program jointly by the Department of Pediatrics of the School of Medicine and the School of Nursing of the University of Colorado.¹⁻³

In 1971, the American Nurses' Association and the American Academy of Pediatrics recognized that a collaborative effort was necessary to increase the quality, availability, and accessibility of child health care. These two organizations approved the concept of the Pediatric Nurse Associate (the titles— Pediatric Nurse Associate and Pediatric Nurse Practitioner are used interchangeably) and developed the "Guidelines on Short-Term Continuing Education Program for Pediatric Nurse Associates."^{4,5}

The National Association of Pediatric Nurse Associates and Practitioners (formed in 1973 and currently representing 40% of the PNP/As) and the American Academy of Pediatrics published a joint statement regarding the PNP/A in 1975. I have enclosed a copy of this scope of practice for your information.

NAPNAP does not support independent practice for pediatric nurse practitioners/associates. We fully realize that certain medical services delegated to the PNP/A is still the responsibility of the physician and must be performed under his direction, supervision, and review. But, as an interdependent member of the health team, the PNA/P actively participates in coordination and collaboration and assumes a direct role in preventive health care delivery and child health advocacy.

One final comment— while some members of the American Academy of Pediatrics have voiced opposition to the pediatric nurse practitioner concept, I challenge Dean Torres' statement that the Academy has withdrawn support of the PNP/A. NAPNAP and AAP continue to have a good professional relationship and share many liaison activities.

Sincerely,

/s/Margaret K. Hicks, RN, BS, CPNA
President & fellow, NAPNAP

Bibliography

1. Ford LC and Silver HK: "The Expanded Role of the Nurse in Child Care." *Nursing Outlook*. 15:43-45 (Sept.) 1967.
2. Silver HK, Ford LC, and Day LR: "The Pediatric Nurse Practitioner Program." *Journal of American Medical Association*. 204:88-92 (April) 1968.
3. Silver HK, Ford LC, and Slearly AG: "A Program to Increase Health Care for Children: The PNP Program." *Pediatrics*. 39:756-760 (May) 1967.
- 4-5. A Joint Statement of the American Nurses' Association, Division of Maternal and Child Health Nursing Practice, and the American Academy of Pediatrics: "Guidelines on Short-Term Continuing Education Programs for Pediatric Nurse Associates." *American Journal of Nursing*. 509-512 (March) 1971. *Pediatrics*. 1075-1079 (June) 1971.

To the Editor.— In response to your article "Facing The Free Riders" that appeared in the December issue of OSMA I would like to ask a few questions and make a few comments.

Perhaps OSMA has addressed the issue in Ohio. By requesting help from the legislature to stem the tide of malpractice insurance we got the JUA along with a

(continued on page 132)

mandatory 150 hours every 3 years.

There should be a study by the OSMA as to the effect in the loss of practicing physicians directly or indirectly attributable to this discriminatory legislation.

Don't misunderstand, I am not against CME and have done so every year that I have been in practice. There were always adequate courses available to anyone who wanted to enroll. I took the courses because I wanted to, not because I had to. No profession has higher education standards than medicine. Now by law we attend meetings and get our cards punched like a bunch of grade schoolers.

This law has forced one retirement in our area and is threatening another. Some of you think that anyone 75 years old should retire. George Meany was 84 years old and the last speech I heard him make did not sound senile. Age should be no factor. Mental capability should.

A physician in Deshler received a notice of suspension. He has requested an extension and may receive it because of illness. However, that will be temporary unless he turns in the CME credit hours.

In the urban areas these losses may not have any effect. In the rural areas it does. The physician had about

eight patients in the local rest home that were referred to me, plus there will be many more from the McComb area who will want and need medical services that the specialty-oriented area of Findlay will not or cannot supply.

The AMA must make itself "wanted and needed" to increase its membership. Trying to manipulate increased membership by pressure is not only revolting, the day the AMA becomes a closed shop I predict the membership at large will revolt.

Respectfully,
/s/ R. J. Blough, M.D.
Deshler, Ohio

Opinions expressed in the Letters to the Editor Section are those of the authors, and do not necessarily reflect OSMA policy. Letters will be printed as space permits and in the sole discretion of the editor. All letters should be typewritten double-spaced and no more than 250 words in length. The Journal reserves the right to edit all letters.

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Indochinese Refugees in Ohio - 1980

Thomas J. Halpin, M.D., M.P.H.

In the fall of 1979, the President announced the United States would accept 14,000 Indochinese refugees per month. The West Coast will receive much larger concentrations of refugees than Ohio; however, over the next 18 months an additional 4,000 refugees will be resettled in Ohio. Presently, there are 3,700 Indochinese refugees residing in Ohio. Many of the refugees coming to the United States now may have spent years in refugee camps in Thailand. They are likely to have more medical problems than the more affluent and well-educated Vietnamese who migrated to the United States in 1975 and 1976 after the fall of Saigon. However, where illness is present it is likely to represent a personal rather than public health problem. The usual chronic disease problems similar to those seen in the United States will be common. These will be aggravated by malnutrition and poor hygiene due to crowded camp living conditions. Perhaps the greatest personal health problem will be caused by the stresses of resettlement.

Some refugees may have exotic medical conditions, exotic, however, only by United States standards. Many of these diseases, such as malaria, will be due to parasites. A refugee with a fever and/or anemia, splenomegaly, chills, headache, backache, and malaise should lead one to suspect malaria. The malarial parasite may be chloroquine-resistant, and this will have to be taken into account when prescribing a treatment regimen. Other parasitic infections such as hookworm, *Giardia*, *Trichuris*, and *Ascaris* may be common.

Most conditions encountered will be personal health problems, however, there are a number of diseases more commonly seen in the refugees which will pose a public health threat. Approximately 1% to 2% of the refugees may have active tuberculosis. Although screening takes place in refugee camps in Southeast Asia before entry into the United States, recent studies have shown that a number of active cases at screening have been called inactive and the reverse also has occurred. This allows some active cases to go untreated but also forces inactive cases to receive inappropriate drug treatment and perhaps hasten

the development of resistant organisms. Because of these discrepancies, the Ohio Department of Health is requesting a re-evaluation of any refugee having an entry diagnosis of active or inactive tuberculosis. This will involve approximately 5% of the refugees settling in Ohio. These rechecks usually will be completed by local health officials, but a physician treating an ill refugee, especially one with respiratory symptoms, always should consider the diagnosis of tuberculosis.

Besides tuberculosis, hepatitis type B represents a limited public health threat, but more of a problem to certain physicians and health care workers. Hepatitis B and its chronic carrier state are more common in Southeast Asia than in the United States. As many as 12% of Indochinese refugees may chronically carry hepatitis B antigen as contrasted with a carrier rate of only 0.3% in the general United States population. This antigen can be found in many bodily secretions; however, its usual route of transmission is through blood contact.

Health care personnel handling the blood or serum of an Indochinese refugee should be made aware of the high rate of hepatitis B carriage in these individuals. In many instances, e.g., a refugee hospitalized for surgery, it may be best to test for hepatitis B antigen so the one out of eight or one out of ten who is a chronic carrier definitely can be identified. The fact that any patient, refugee or otherwise, is a chronic hepatitis B carrier should not be a deterrent to appropriate medical care. Using proper technic in the laboratory, operating room, or any other area where blood contamination may occur can prevent the spread of hepatitis B to susceptible health care personnel.

Overall, Indochinese refugees present very little threat to the general public or to those who will care for their ills. Indeed, special care and understanding will have to be taken because of the refugees' difficult circumstances.

Dr. Halpin is Chief, Bureau of Preventive Medicine, Ohio Department of Health.

Efficacy of Ambulatory Gynecologic Surgery

Richard J. Nowak, M.D.

Ambulatory surgical programs which have developed throughout the country have proved to be a convenience for the physician and patient, and have maintained the quality care. An additional benefit has been the cost effectiveness nature of these programs. One such program in gynecologic ambulatory surgery has been approved by the American Medical Association, The American College of Obstetricians and Gynecologists, and third-party payers.

The recent literature on cost effectiveness is very confusing and difficult to interpret. It is difficult, for example, to obtain data on the actual costs of ambulatory surgery versus inpatient surgery because the cost allocation technics vary from hospital to hospital. Some studies show that teaching programs add significantly to the costs for hospitals. Third-party payers add another dimension to cost allocation. In some instances 90% of inpatient costs may be reimbursed while only 40% of ambulatory costs will be covered.

It would seem to be common sense that the ambulatory surgical patient saves one day of hospital bed charges. However, the hospitals do not use a direct costing system. The overlapping of cost allocation and third-party requirements is so complex that it is next to impossible to decipher what the costs are between inpatient and outpatient services. Some hospitals with a low occupancy rate are fearful that ambulatory surgery will cause a further decrease in their bed occupancy. The third-party payers maintain that the excess of inpatient beds would create excess demand (Roemer's law) and consequently inappropriate utilization of those beds.

An alternative to hospital-based ambulatory surgery is the free-standing ambulatory surgical unit. It would provide all the necessary facilities suitable for ambulatory surgical procedures and outpatient postoperative care. Of course, there should be a need for a free-standing surgical facility in the community before it is constructed. Otherwise, the local hospital ambulatory surgery would be available at a savings to the community because of the existing facilities.

In discussing cost effectiveness, the physician always is concerned about the quality of care. Available literature provides justification for the intensity of care delivered to inpatients of the hospital compared to the free-standing facility. However, the relationship between quality of care and cost should be placed in its proper perspective. The

general feeling that "more care is better" is a concept that will vary according to intensity of care.

In general, the present status in ambulatory surgery is developing to a point at which over 40% of cases tend to be gynecologic. Most common procedures are laparoscopy and D & C.

Of utmost importance is the role of anesthesia. The anesthesiologist must keep all medications and anesthesia to a minimum to allow rapid recovery and discharge in approximately two hours.

The patient is advised to have nothing to eat or drink after midnight prior to the surgical procedure. The patient's history, physical examination, and order sheet are submitted in advance. A day before the surgery the patient goes to the hospital and has the CBC, urinalysis, fasting blood sugar, BUN and chest x-ray performed. If the patient is over 35 years of age an EKG is ordered. There should be no medical problems such as pulmonary, heart, kidney, or systemic disease present.

The types of gynecologic surgical procedures applicable for ambulatory surgery are:

- Pelvic examination under anesthesia
- Vulvar biopsy
- Vaginal biopsy
- Excision of vaginal lesions
- Dilatation and curettage
- Cervical biopsy
- Removal of IUD or foreign body
- Hysterosalpingogram
- I & D of Bartholin abscess
- Laparoscopy
 - diagnostic
 - sterilization
- Minilaparotomy for tubal ligation

Postoperative problems may be recognized in the immediate recovery period while the patient is in the recovery room.

The patient is discharged in approximately two hours by the anesthesiologist after the postoperative recovery is complete. A prescription for an appropriate analgesic may be in order and follow-up care is provided in the office.

Ambulatory surgery is an alternative which should be cost effective without compromising the quality of care.

Dr. Nowak, Cleveland, is a member of the OSMA Committee on Cost Effectiveness.

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Reference: 1. Hellerstein HK, Friedman EH: Sexual activity and the postcoronary patient. Arch Intern Med 125:987-1970

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Antitrust and the Medical Society

by Dennis L. Breo

Editor's Note:

With this issue, the Journal begins a series of interviews with prominent individuals discussing social and economic issues involving the practice of medicine.

This month's interview is with Betty Jane Anderson, J.D., an attorney with the AMA. She discusses the relationship between the medical society and the Federal Trade Commission.

From her sixth-floor office in the Chicago headquarters of the American Medical Association, attorney Betty Jane Anderson commands a panoramic view of one of the world's great medical cities.

Clustered within blocks of each other are the Northwestern University Medical Center, the national headquarters of the American Hospital Association, Blue Cross Association, Blue Shield Association, American Dental Association, and scores of national medical specialty societies.

"B.J.," as she is widely known throughout medicine, has had this view for 15 years now. And during that time, the occupants of the medical building outside her window have come to be identified as small parts of a giant cartel.

The sober reality today, B.J. said in a recent interview with *The Executive*, is that "The Federal Trade Commission is interpreting health care as an industry, physicians and allied health professionals as tradesmen, and the interactions of all the parts as a cartel.

"It's all part, I believe, of a softening-up process to subordinate physicians to a program of national health insurance. But, like it or not, physicians have to recognize that within the past four years both the FTC and the antitrust division of the U.S. Justice Department have launched broad attacks on what they see as 'anticompetitive' practices in health care. The trustbusters in Washington are coming down on physicians with charges of price-fixing and restraint of trade."

Early Warnings

The attacks are not entirely surprising to the AMA assistant general counsel. When she joined the Association in 1964, one of her first items of research was to study the 1890 Sherman Antitrust Act and its potential impact upon medicine.

"I became familiar," she said, "with the 1943 Supreme Court case in which the American Medical Association and several codefendants were convicted of criminal conspiracy against a prepaid health plan in the District of Columbia.

"We at the AMA have always operated on the premise that medicine is subject to the Sherman Act and our advice to the AMA has consistently been on this basis. As you know, the organizations that we represent do not always listen to their lawyers and, if they do, they are not always in a position to follow the advice, in whole or in part. This is properly so."

Within a year of B.J.'s employment at the AMA, the U.S. Congress enacted Medicare and Medicaid and the stage was set for today's showdown between professional privileges and what the FTC and Justice find are the needs of a free medical market.

During the 14-year interim between passage of Medicare and today's antitrust climate, B.J. has established herself as one of this nation's foremost experts on health law. After she addressed a recent AAMSE seminar on "How To Avoid Antitrust Problems," medical executives rushed for the telephones and directives went flying across the country. Many a decision-making medical committee has changed its mind after hearing some cautionary words from B.J.

She can be humorous—"If Hippocrates were living today, he would have to clear his Oath with the FTC"—but her message is stern: "Medicine must meet the public's demand for a new accountability—that physicians and their organizations are acting for the general good and not purely professional self-interest."

A Vexing Challenge

Her charge to medical executives is both troublesome and challenging:

"Acquire an understanding of antitrust law sufficient to guide the activities of your organization to avoid antitrust problems."

Until a few years ago, she said, knowledgeable attorneys were divided on whether or not the "learned professions" like medicine and law are exempt from the antitrust act. That doubt, of course, was resolved when, in 1975, the Supreme Court ruled in the Goldfarb case that, "Indeed, they are." (Goldfarb had gone shopping for attorney estimates to handle a real estate closing and found the minimum fee charged by several attorneys to be precisely the same. The Supreme Court ruled that minimum fee schedules of bar associations constitute price-fixing.)

The AMA attorney states the problem simply:

"As interpreted by the courts, a professional association is in violation of the Sherman Antitrust Act if it engages in an unreasonable restraint in or affecting interstate commerce. The professions are now considered to fall under the terminology of a trade.

"When physicians or their organizations engage in activities that curtail other physicians or other health care professionals from engaging in legitimate activities, there

"The survival of professionalism depends upon continuing public support. We can survive attacks by government, but we cannot survive a loss of public faith."



may be a violation of the law. Let me give you a concrete illustration.

"The medical specialties are not divided into self-contained cubicles. They overlap. What internists do, so may family physicians, pediatricians, and gynecologists do. The same principles apply to some of the work performed by plastic surgeons, otolaryngologists, and dentists, and to some of the work done by orthopedic surgeons and podiatrists. Jurisdictional battles between medical specialists or between physicians and other health care professionals have the potential of clearcut violation of the Sherman Act."

Records Retention

And she states the potential solution just as simply:

"Retain a good attorney who is familiar with antitrust law and maintain sensible records for all correspondence, memoranda, and papers.

"Good legal talent is expensive today. If your county medical society is so small that it is not feasible to retain an attorney on a regular basis, sometimes the attorney for the state medical society may be available. No state medical association can afford not to have a regular relationship with an attorney qualified in business and antitrust law.

"And, remember, your written files are subject to examination by the HEW, IRS, FTC, Justice Department, state agencies, even citizens engaged in litigation. All letters that leave the office should be written as if intended for publication or the eyes of government investigators and adversaries in litigation. If kept long enough,

everything in your files will receive such scrutiny. Avoid loose and careless language and overstatements.

"The AMA was involved in a case a few years ago where a letter from the Association's files contained the following handwritten notation written in the margin: 'Let's give him a fair hearing before we hang him!' That case, fortunately, was settled out of court. Do not write marginal notes on materials retained in your files. In the case the AMA is currently involved in brought by the FTC, we have seen many such marginal notations on documents obtained from the files of county and state medical societies and introduced as evidence against the AMA. Develop and implement a records retention policy. The AMA can provide you with a helpful document on how to do it."

Although B.J. and most others feel that the FTC's first initiative against the AMA—a complaint charging that the Association's time-honored code of ethics prohibiting the solicitation of patients is an anticompetitive measure unfairly barring physician advertising that would lower costs—is "so stupid as to be ludicrous," she is settled in for a long siege.

Mountains of paperwork pile up on her desk, much of it involving antitrust cases. One of the reasons the paperwork piles up is the long list of phone calls she receives every day; calls from people in the field needing help on antitrust matters. Also, she must travel to and from Washington, D.C., and elsewhere to argue this issue.

Occupying a choice location in the cabinet behind

(continued on page 138)

her desk is an art object more precious to her than the framed photos of famous English barristers that line the walls.

The favored object is a bird, the mythological Jay-hawk that early settlers of Kansas adopted as its symbol of prevailing despite adversity. The harsh Kansas land tested those early Kansas settlers, but they survived. B.J., a graduate of Kansas University, thinks that medicine, too, will survive the antitrust assault.

She offers medical executives the following elaboration on potential antitrust trouble spots and potential ways to avoid them.

Trouble Spots

"Some of the trouble spots where you can expect action from the FTC or Justice Department," she said, "are these:

- "If a medical society is telling its members to avoid salary arrangements with hospitals and stick only to percentage or fee-for-service arrangements.
- "If it is discouraging salaried employment with HMOs.
- "If it is discouraging physicians from participating in service third-party payment plans.

- "If a hospital insists upon new X-rays and lab tests and insists upon disregarding X-rays and lab tests made outside the hospital. Government believes with considerable justification that the hospital is motivated more by economics than quality care.
- "Radiologists and pathologists who conduct laboratories outside of hospitals will find government taking a position that their exclusive leases in medical office buildings are in restraint of trade and therefore invalid.
- "Medical groups that require partners and employees to sign agreements that they will leave the community and not compete after retirement can expect FTC trade rules that invalidate such arrangements. AMA doesn't like these arrangements, although within certain parameters they are not unethical.
- "FTC feels that Blue Shield boards should not be controlled by medical societies, preferring control by public or so-called consumer members, with MDs a minority. Public and consumer representation should be encouraged on Blue Shield boards. This can be helpful to medicine and

(continued on page 140)

"If Hippocrates were living today, he would have to clear his Oath with the FTC."

NEXT MONTH: An interview with State Senator John K. Mahoney (D-Springfield) chairman of the Ad Hoc Committee to Study the Cost of Health Care in Ohio — what his committee found and what it plans to do about it.





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- "Although the administrative judge's decision prohibiting AMA and its constituent and component organizations from disciplining members for any kind of advertising, even if it is fraudulent, is not yet effective, I would suggest that this kind of discipline should be carefully considered before action is taken. If you have a member who engages in false advertising and patients are hurt because of incompetent treatment on the part of the advertiser, or because the advertiser misled the patient through advertising to undergo risky treatment with dire consequences, there is a remedy. Don't discipline him for advertising. Go after him for bad treatment.

"Medicine must meet the public's demand for a new accountability — that physicians and their organizations are acting for the general good and not purely professional self-interest."

- "Third-party plans need stabilized physicians' fees in order to determine premiums for medical and health insurance. Some medical societies have previously assisted in the process, but this is now quicksand. If you are running a committee to help third-party payers determine what is reasonable payment for physicians' services, stop. Third-party payers can themselves hire practicing physicians on a part-time basis, if they wish. But it should not be done by a medical society.
- "Can you discipline physician-members who exploit patients by fee-gouging? I would say yes, but your statistics should show that what you are doing is trying to protect the public against those few physicians who are rascals. In other words, the complaints considered should emanate primarily, but not necessarily exclusively, from patients, not insurance carriers.

"The complaints considered from insurance carriers should be dealt with only on the basis of whether the physician should be disciplined for fee-gouging and not for the purpose of determining a fair or reasonable fee or fee adjustment."

Future FTC Forays

The AMA attorney warns of ominous future FTC excursions.

"Once jurisdiction is firmly established," she said, "over the so-called 'health industry'— a term I don't like

because once you call a profession an industry you recognize government's affinity to regulate industry— you can expect trade rules and controls over physicians and hospitals in the name of 'consumer protection.'

"In the role of a 'Big Brother' ombudsman for patients, I can see the FTC in the position of scrutinizing JCAH standards; or, perhaps, making sure that FTC standards are applied to the operation of hospital tissue committees. Far fetched? You wait and see, and it won't be too long.

"Another area for FTC involvement is 'captive laboratories' owned by physicians who funnel their patients for lab services. Also, physician-owned drug repackaging enterprises. These are likely to come under scrutiny as unfair trade practices.

"The FTC is already active in the ophthalmic field. We can expect more activity, particularly with respect to dispensing of glasses.

"FTC interest will be expressed toward the volume dispensing of drugs in areas where there are ample retail pharmacies.

"In the vernacular of antitrust, those physicians and limited practitioners who seek, but can't get hospital privileges, consider themselves victims of a 'boycott.' FTC rules governing hospital privileges are not at all beyond the realm of possibility within the next five years, if the present trend is allowed to continue.

"There are FTC footprints on the medical education scene that indicate FTC investigation of board-certifica-

"The sober reality today, is that the Federal Trade Commission is interpreting health care as an industry, physicians and allied health professionals as tradesmen, and the interactions of all the parts as a cartel."

tion requirements is on its timetable for future litigation.

"FTC is concerned about the exclusive medical care jurisdictions carved out by the various medical specialties and whether requirements are necessary, fair, and basically related to economics, not quality."

In guarding against these potential FTC problems, the health law expert cautioned, it is wise to remember that, "Good intentions are not enough. The road to the courthouse is paved with them. Be alert about anything you do that interferes with the business activities of other people. Even though you are convinced that what you contemplate is in the public interest."

Potential Solutions

B.J. emphasized to medical executives the need for

potential solutions— retaining a good attorney, keeping sensible records, and guarding against questionable restraint-of-trade policies.

"If a medical organization is big enough to afford the full-time services of a salaried lawyer, he can be a watchdog of the activities that might create antitrust problems," she said. "Make certain you hire a watchdog and not a pussy cat, if you go this route.

"Be cautious with the minutes kept of board and committee meetings. The minutes of board meetings should state only the actions taken. It is not necessary nor desirable to record the discussion. Retention of the agendas prepared for such meetings is not necessary.

"At the AMA, all resolutions introduced by delegates are screened by the Office of General Counsel. What is done is this— the lawyer reads the resolution with the object of understanding what the resolution intends to accomplish and whether the intended result can be accomplished legally. On the average, fewer than 3% of the resolutions pose potential antitrust problems and most of these can be cured by a minor change of language without disturbing the intent of the delegate who introduced the resolution.

"Despite these precautions, every two or three years

a particular resolution results in a call from the U.S. Department of Justice or a suit."

The AMA assistant general counsel urged medical executives to guide their physician organizations toward "responsible policies that neither restrain trade nor abdicate the medical profession's traditional concern for quality care. This tightrope can be walked.

"What we are facing are new demands from the public for accountability. Physicians and their organizations must demonstrate that what is good for medicine is good for the public. This is not always the case, and medical execs must help their organizations make decisions that serve the public as well as the profession.

"The survival of professionalism depends upon continuing public support. We can survive attacks by government, but we cannot survive a loss of public faith."

"We never want medicine to become an industry with 400,000 physicians acting as 'tradesmen.' We want the public to continue to want their physicians to be known and to respond as professionals."

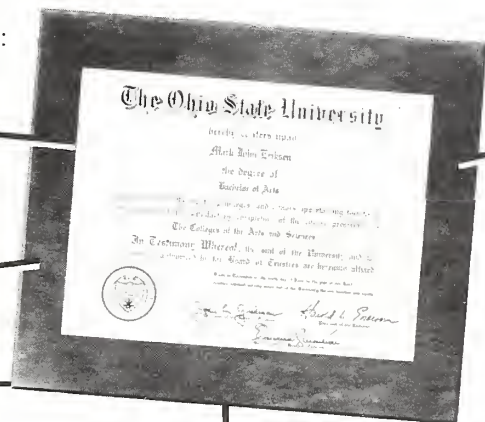
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Dennis Breo is editor of *The Executive*.

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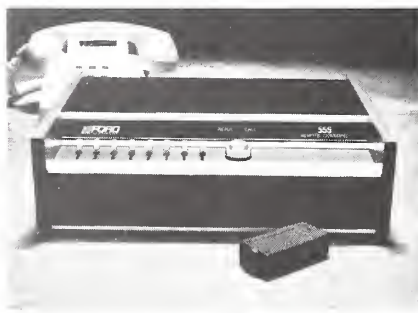
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MARCH

SYMPOSIUM ON THE AGGRESSIVE ADOLESCENT: March 28, Carrousel Inn, Columbus; speakers: Rudolf Ekstein, Ph.D., Derek Miller, M.D., Hans Stroo, M.D.; discussants: L. Eugene Arnold, M.D., Jane Kessler, Ph.D., Marcel Hundziak, M.D.; sponsor: Harding Hospital, Worthington; 7 credit hours; fee: \$30; contact: Registrar, Harding Hospital, 445 E. Granville Road, Worthington 43085, phone: 614/885-5381, ext. 326.

APRIL

GYNECOLOGIC SURGERY AND ONCOLOGY: April 17; Carrousel Inn, Cincinnati; sponsor: University of Cincinnati Medical Center, Dept. of Obstetrics & Gynecology; 6 credit hours; fee: \$75, \$35 (residents and other, health professionals); contact: Joanne Clyburn Office of CONMED; 231 Bethesda Ave., Cincinnati 45267; phone: 513/872-5486.

SPORTS MEDICINE SYMPOSIUM: April 17-19; Bond Court Hotel; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: \$125; contact: Center For CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, 44106, phone: 216/444-5696.

SIXTEENTH ANNUAL SYMPOSIUM ON RHEUMATIC DISEASES: April 23; Holiday Inn, 6001 Rockside Road, Cleveland; sponsor: Cleveland Clinic Educational Foundation; cosponsors: Cleveland Rheumatism Society and The Arthritis Foundation; 6 credit hours; fee: \$35, no fee for medical students, interns and residents; contact: William Wilke, M.D., The Arthritis Foundation, Northeastern Ohio Chapter, 11416 Bellflower Road, Cleveland 44106, phone: 216/791-1310.

MAY

CONSULTATIONS AND DISCUSSIONS IN HAND SURGERY: May 8, 9, 10; Hilton Inn West, Akron; sponsor: American Society for Surgery of the Hand; 17 credit hours; fee: \$250, \$100 for residents with letter from Chief of Service; contact: Thomas Reef, M.D., 300 Locust St., Akron 44302, phone: 216/376-6846.

MEDICINE AND RECENT TRENDS IN CLINICAL CHEMISTRY: May 8-9; Bond Court Hotel, Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$100, \$50 physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone 216/444-5696.

THE NORMAL MENSTRUAL CYCLE AND HOW TO REPLACE IT: May 8; Community Med-Center Hospital Conference Room, Marion; sponsor: Community MedCenter Hospital; one credit hour; no fee; contact: Judith A. Murphy, 1050 Delaware Avenue, Marion 43302, phone: 614/387-0850, ext. 219.

25TH ANNUAL MEETING OF THE OHIO CHAPTER, ACS: May 10-11; Stouffer's Dayton Plaza Hotel, Dayton; Sponsor: Department of Continuing Education, Wright State University School of Medicine; 10 credit hours; fee: no charge to members, nonmember practicing physicians \$25; contact: Vickey McVay, Ohio Chapter, ACS, 600 South High Street, Columbus 43215, phone: 614/228-6971.

IMMUNODYNAMICS III: IMMUNOREGULATION AND AUTOIMMUNITY: May 12-13; Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 11 credit hours; fee: \$125; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

(continued on page 146)

EDUCATION PROGRAMS (continued)

CONTACT LENS WORKSHOP — 1980: May 16-17, Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

40TH OHIO STATE RADIOLOGICAL SOCIETY ANNUAL MEETING: May 16-18; Atwood Lake Lodge Resort, Dellroy; sponsor: American College of Radiology; 9 credit hours; fee: no charge to members, nonmember physicians \$20; contact: Vickey McVay, Ohio State Radiological Society, 600 South High Street, Columbus 43215, phone: 614/228-6971.

22ND ANNUAL REFRESHER COURSE IN DIAGNOSTIC RADIOLOGY: May 27-May 31; Netherland Hilton, Cincinnati; sponsor: University of Cincinnati Medical Center; 35 credit hours; fee: \$250; contact: Harold B. Spitz, M.D., Dept. of Radiology, Cincinnati General Hospital, Cincinnati 45267, phone: 513/872-4396.

UPDATE ON PAIN—MANAGEMENT OF CANCER PAIN BY THE PRIMARY CARE PHYSICIAN: May 28; Sheraton Downtown Dayton; sponsor: Wright State University School of Medicine; 8 credit hours; fee: \$55, \$40 (WSU Faculty); contact: Arlene Polster, Wright State University, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

ANESTHESIA AND THE HEART PATIENT: May 30-June 1; Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 20 credit hours; fee: \$275, \$200 (physicians-in-training); contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

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PROCEEDINGS OF THE COUNCIL

January 26-27, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, January 26, and Sunday, January 27, 1980 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; John H. Ackerman, M.D., Columbus.

Those present from the OSMA staff Saturday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Rick Ayish, David C. Torrens, Carol W. Mullinax, David W. Pennington, Eric Burkland, Jennifer O'Brien.

Those present Sunday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Joseph P. Yut, M.D., Canton; Carl E. Spragg, M.D., New Concord; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; Tom Martin, CAE, Shawnee Mission, Kansas.

Those present from the OSMA staff Sunday were: Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, David W. Pennington.

The president introduced Jennifer O'Brien, new research associate of the OSMA legislative department.

The president congratulated Jerry J. Campbell, who was chosen president-elect of a national organization of his peers, The Professional Convention Management Association, at the annual meeting of that organization in Kansas City, Missouri, January 6-10, 1980.

The minutes of the December 15-16, 1979 meeting were approved.

The president commemorated the fact that a historical landmark was set in December, when the membership of the OSMA reached an all-time high, passing the twelve-thousand level.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Mrs. Wisse reported that membership shows more rapid growth this year over the previous year.

Auditing and Appropriations Committee

The Council approved a January 26, 1980 recommendation of the Committee on Auditing and Appropriations with regard to Mr. Edgar's retirement gift and for the contribution for plan year beginning December 31, 1978 to the Employees Pension Trust.

Treasurer's Report

Dr. Barr presented a cash management report with regard to Association investments.

DEPARTMENT ON CONTINUING MEDICAL EDUCATION

Mrs. Dodson discussed arrangements for the annual meeting, indicating that Mr. Torrens will be handling the caucus room arrangements.

Dr. Yut reported that the Ohio State Medical Board has approved the OSMA CME Program for the triennium January 1, 1980 through December 31, 1982.

DEPARTMENT OF GOVERNMENT RELATIONS

Membership Committee

Mr. Gillen presented the January 19, 1980 minutes of the Membership Committee.

The Council approved the following recommendations developed by the Membership Committee, with assistance from the Staff Task Force on Membership Promotion:

1. Identification of key physician contacts in each county.
2. Data assembly from the AMA and the State Medical Board to identify potential membership prospects by geographic distribution and target groupings.
3. Councilors and OSMA staff work with county society leadership and executives to encourage more counties to utilize the OSMA dues billing service.
4. Further study on the use of the credit card for paying dues.
5. Suggestion of four counties for an all out membership recruitment campaign.
6. Implementation of two activities regarding faculty recruitment: (1) A survey be made of non-OSMA members of the OSU College of Medicine faculty, and (2) A listing of non-OSMA members of the Medical College of Toledo faculty be sent to Dr. Baibak for the development of a personal contact program. Each activity is to develop information on why some faculty members choose not to be members.

(continued on page 149)

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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7. A pilot program in Toledo for recruiting residents with initial emphasis on chief residents. The Council suggested that attention be directed toward working with Directors of Medical Education on this matter.

The Council *approved*, with one dissenting vote, the Committee's recommendation that specialty societies, with vote, should be represented in the OSMA House of Delegates and asked that a recommendation containing specific criteria for specialty society representation be prepared for Council consideration at its March 1-2, 1980 meeting, along with a draft resolution to amend the Constitution and the Bylaws.

The Council decided to study the concept of a 25-year membership recognition program.

The report as a whole, as amended, *was approved*.

Committee on Cost Effectiveness

Dr. Pfahl presented the minutes of the January 25, 1980 meeting of the Committee on Cost Effectiveness.

A request for a letter from the President of OSMA to the members regarding cost effectiveness effort *was approved*.

Health Planning Update

Mr. Pennington reported on recent developments concerning the study by physicians throughout the state of health planning activities.

DEPARTMENT OF ORGANIZATION SERVICES

Dr. Clarke reported for Ohio's AMA Delegation, including the data on the AMA Accountability Report, the details of which were presented by Mr. Campbell.

The system received praise as a communications instrument.

The Council voted to continue the system as it has been implemented, both the accountability and report.

Medical Services Review Committee

A report of the January 26, 1980 meeting of the Committee on Medical Services Review was presented by Dr. Dorner and *was approved*.

Joint Underwriting Association

Current Joint Underwriting Association statistics were presented by Mr. Campbell. Mr. Campbell was asked to get additional information regarding Stabilization Reserve Fund statistics.

Task Force on Professional Liability

Mr. Campbell reported the minutes of the January 25, 1980 meeting of the Task Force on Professional Liability.

The Council *approved* the Task Force recommendation that a report regarding the advisability of introducing legislation to repeal or modify the mandatory nonbinding arbitration provision in Ohio Law (HB 692) be accepted for information and filed.

The status of implementation of several resolutions passed by the OSMA House of Delegates was presented.

Approved were recommendations of the Task Force concerning the OSMA position with regard to proposed

administrative rules for the phasing out of both the Stabilization Reserve Fund and the Joint Underwriting Authority.

Approval was given to the OSMA legal counsel to file an amicus curiae brief regarding a case in which a physician's right to withhold settlement is at issue.

DEPARTMENT OF HEALTH EDUCATION

Committee on Health Manpower

The minutes of the December 12, 1979 meeting of the Committee on Health Manpower were presented by Mr. Clinger. The minutes *were approved*.

Subcommittee on Impaired Physicians

The minutes of the Subcommittee on Impaired Physicians of the Committee on Mental Health for January 6, 1980 were presented by Mr. Clinger.

The Council *approved* the addition of a physician and a staff member from the Ohio State Medical Board to the subcommittee.

A regional conference on the Impaired Physicians *was approved* for March 7-8, 1981.

OSMA/ONA Liaison Committee

Mr. Clinger reported on a meeting of the OSMA/Ohio Nurses Association Liaison Committee, which was held January 9, 1980.

Ad Hoc Subcommittee on Resolution 14-79

Mr. Clinger presented the minutes of the Ad Hoc Subcommittee meeting on Resolution 14-79, of January 15, 1980. The report *was approved*.

Ohio Communicable Disease Reporting Project

Mr. Clinger presented a status report on the Ohio Communicable Disease Reporting project for information.

A motion to send staff to the meetings of the various licensing boards *was approved*.

DEPARTMENT OF STATE & FEDERAL LEGISLATION

Committee on State Legislation

The minutes of the January 23, 1980 meeting of the Committee on State Legislation were presented by Dr. Ford.

H.B. 753, to require Ohio to license all hospital and ambulatory care facilities was discussed. The Council *approved* the measure contingent upon successful amendments to provide (a) that admissions to hospitals be only by a physician or a dentist and (b) that all medical services must be under a physician's direction and supervision. The Department was instructed to clarify or amend Sec. 3701.40.

Approved, with one dissenting vote.

H.B. 554, home health care. The Council *approved* a recommendation that the Department seek amendments that would provide that physicians review home health care programs and supervise the medical aspects thereof.

(continued on page 150)

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AVAILABLE: Bottles of 100, 500.

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Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

H.B. 879, abortion—informed consent—impact on practicing physician. The Committee recommended that all elements which require additional reporting and inspections on the part of the physician be eliminated; requirement that two physicians be present at abortion of potentially viable fetus be deleted; that parental consent or judicial review was acceptable for females under 16, but 22-day waiting period be deleted.

The Committee also recommended that all requirements for standards of informed consent for abortion different from those for other surgical procedures be deleted.

The Council accepted a committee recommendation that language against abortions after 24 weeks of gestation of a live fetus, in absence of danger to life or health of the mother, be approved.

Dr. Kilroy presented a minority recommendation on the areas with regard to requiring two physicians present in delivery of potentially viable fetus and concerning informed consent, asking endorsement of the more detailed informed consent procedure as provided in the bill.

The Council *approved*, with one dissenting vote, the majority recommendations, except that one requiring "two physicians" and the special "informed consent" provisions.

On the requirement for two physicians, the majority recommendations prevailed, with two dissenting votes.

On informed consent provisions, the majority recommendations were carried, with four dissenting votes.

The majority recommendations of the committee with regard to areas of the bill impacting on physicians *were then approved*.

Medical Practice Act

Medical Board recommendations for revisions in the Medical Practice Act were discussed.

The Council asked that such a bill not be introduced at this time; the Board be so notified; and that a subcommittee of the Council be appointed to meet with officers of the Board with regard to the proposal.

Federal Legislation

Mr. Mulgrew reported on S. 1991 and the McClure amendment.

Proposed Rule Changes—Board of Pharmacy

Regarding proposed rules of the Board of Pharmacy docketed for hearing on February 27, 1980, the Council voted strong opposition to the amendments expanding the pharmacy rules to include parts of the practice of medicine.

Mr. Burkland reported that S.B. 160, to reorganize local MH & MR Boards, has been amended to mandate physician representation. The report of the Committee on State Legislation *was approved*.

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COMMUNICATIONS DEPARTMENT

Ms. Mullinax reported that Republic Steel has agreed to initiate a pilot project to distribute *Synergy* to its employees.

Ms. Doll reported on *Journal* developments and projects of the Committee on Public Relations.

FIELD SERVICE DEPARTMENT

Dr. Dorner and Mr. Holcomb presented proposed model bylaws for county medical societies.

The Council voted to *approve* the model contingent on suggested changes, if any, as agreed upon by the Chairman, Legal Counsel, the Communications Director and the Field Service Director.

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

With respect to a Fifth District communication regarding coverage, billing, and reimbursement of salaried house physician services, the matter was discussed by the Council and was referred to the Committee on Government Medical Care Programs.

OHIO DIRECTOR OF HEALTH

Dr. John H. Ackerman, Ohio Director of Health, addressed the Council.

He reported on beginning outbreaks of type "B" influenza in Ohio and thanked Ms. Mullinax for her article on Reye's Syndrome in the February issue of *Synergy*.

He distributed a December, 1979 report on Primary Health Care Initiatives in Ohio: Bureau of Community Health Services U.S. Department of H.E.W.

He announced retirement of George Compson as legal counsel of the Department and the appointment of Mr. Steadman Oberman to serve in that capacity.

LONG RANGE PLANNING

The Council decided to consider proposals of outside consultants to assist in assessing the structure of the Association.

ATTEST: Hart F. Page, CAE
Executive Director

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Legislative Overview

Editor's Note:

The following is a review of legislation currently under consideration by the Ohio Legislature. The OSMA Department of State and Federal Legislation is closely monitoring these bills and is available to answer any questions physicians may have as to pending legislation or OSMA's position on a specific bill. The Journal expresses its appreciation to D. Brent Mulgrew, Esq., Director, Richard Ayish, Associate Director, Eric Burkland, and Jennifer O'Brien for their assistance in developing this information.

HB 753 (Thompson, D-Cleveland) HOSPITAL LICENSURE

HB 753 requires Ohio to license all hospital and ambulatory care facilities. "Ambulatory care facilities" originally included the office of physicians in private practice, but efforts of the OSMA Office of State Legislation to exempt physicians' offices from licensure were successful. A recent amendment supported by the OSMA restricts hospital admissions to those authorized by a physician or dentist, and specifies that inpatient care must be provided and supervised by a physician.

HB 700 (Eckart, D-Euclid) — HOSPITAL SERVICE ASSOCIATION LAW CHANGES

SB 231 (Valiquette, D-Toledo), and the identical HB 700 require Blue Cross to provide "incentives" for hospitals to "eliminate services and inappropriate utilization." The measure also permits subscribers to appeal rate increases granted by the Department of Insurance directly to the Ohio Supreme Court. Blue Cross would be required to protect its subscribers from personal liability for services received at a hospital if those services are judged "unnecessary or inappropriate." In addition, Blue Cross would be mandated to establish its own system of inpatient services review, replacing utilization review programs that exist in hospitals. The bill, drafted by the Attorney General's office, currently is receiving hearings in a subcommittee chaired by John Mahoney (D-Springfield). The OSMA will oppose the mandated creation of additional and unnecessary utilization review by the "Blues."

HB 554 (Corbin, R-Dayton) — HOME HEALTH CARE

HB 554 defines a home health agency as one that provides part-time or intermittent nursing care, part-time or intermittent homemaker-home health aide services,

and one of a number of medical/social services. Periodic assessment of the patient and adjustment of the health care plan would be required. The OSMA was successful in amending the bill to require physician assessment of the health care plan. The bill is in the Senate Education and Health Committee.

SB 311 (Mahoney, D-Springfield) — COVERAGE OF PHYSICIANS' OFFICES IN CON PROGRESS

SB 311 extends Certificate of Need (CON) review to physicians' offices when purchasing medical equipment. The bill also establishes a state fund, generated by a tax on hospitals for 50 cents to \$1 per patient day, for the retirement of debt on hospital facilities that are designated as "excess" by health planning agencies. The state would purchase the debt, as well as the facility, at the request of the hospital. The bill will be heard in the Senate Finance Committee.

SB 160/161 (Mahoney, D-Springfield) — REVISION OF MENTAL HEALTH LAWS

SB 160 revises Ohio law regarding appointments, duties, and funding of Community Mental Health Boards. SB 161 transfers responsibilities with respect to the Mental Retardation Program from the Community Mental Health and Retardation Board to the County Board of Mental Retardation. Recent amendments mandating the requirement of two physicians on every 648 board and annual program review by psychiatrists will be challenged by the Ohio Psychological Association and mental health social workers.

SB 184 (Stano, D-Parma) — CONTROLLED SUBSTANCES RESEARCH

SB 184 creates a controlled substance therapeutic research program administered by the Director of Health to research the medical uses of marijuana. The bill establishes a Patient Review Board, consisting of three physicians, to review application for the program. The Public Health Council will adopt rules governing the selection of patients. The entire program has a sunset provision which will phase it out after four years.

SB 271 (Mahoney, D-Springfield) — JUA EXTENSION

The bill extends the Joint Underwriting Association (JUA) for a period of one year, from December 31, 1980, to December 31, 1981. This revision will permit JUA to write policies for coverage until January 1982. SB

(continued on page 154)

271 will return approximately \$25 million of physician contributions from the Stabilization Reserve Fund. An additional \$3 million in savings will be realized this year with the cessation of the SRF surcharge of \$250. The bill passed both houses, and was signed into law, effective in December 1979.

**HB 162 (Tranter, D-Cincinnati) —
CHIROPRACTIC ACUPUNCTURE**

This legislation recently voted out of subcommittee, has been amended to permit any Ohio resident, with a two-year course in acupuncture, and anyone licensed by another state, to perform acupuncture in Ohio. These acupuncturists would be governed by a State Acupuncture Board consisting of three acupuncturists and two lay persons representing the public. The OSMA strongly opposes HB 162.

The bill is before the House Health and Retirement Committee.

**HB 879 (Rocco, D-Parma) —
ABORTION INFORMED CONSENT —
IMPACT ON PRACTICING PHYSICIAN**

The informed consent provisions in the bill require the physician to provide detailed description of the development of the fetus and possible complications that could result from the abortion. Parental consent for abortion would be required of an unmarried woman under 16

years of age, and more detailed records to be reported to Department of Health would be required of physicians and abortion facilities. Abortion after 24 weeks would be prohibited unless the child is not viable, or if the abortion is necessary to preserve the physical or mental health of the patient. Two physicians would be required at any abortion where there is a chance of a potentially viable fetus. The OSMA Committee on state legislation reviewed this legislation and recommended adherence to the 1973 House of Delegates policy on abortion.

**HB 158 (Orlett, D-Dayton) —
OPTOMETRISTS' USE OF DRUGS**

The OSMA was successful last session in preventing the enactment of legislation (SB 163) that would permit nonmedically trained optometrists to administer potentially dangerous drugs. Though the optometric profession is willing to increase the instructional hours required by the bill to 200, it is unwilling to accept a requirement for adequate clinical experience with medical supervision. The OSMA believes adequate clinical training is necessary to prepare an optometrist to administer potentially dangerous pharmaceutical agents. It also fails to see the necessity of a physician referral mechanism for patients with possible pathological conditions. The OSMA continues to strongly oppose optometrists' use of drugs and "diagnosing disease" without adequate training and clinical experience. The bill remains in the House Health and Retirement Committee.

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HOSPICES: MANDATING REIMBURSEMENT

Proposed (but not introduced) legislation would require coverage for services provided by "hospices" in certain subscription contracts, insurance policies, and self-insurance plans. "Hospice" would be defined to mean "a facility that is approved by the Ohio Hospice Organization (a private organization) and that offers a centrally administered program of palliative and supportive services to provide physical, psychological, social, and spiritual care for terminally ill persons and their families. These services would be provided by a medically supervised interdisciplinary team of professionals and volunteers who would be available in both the home and an inpatient setting.

DEATH WITH DIGNITY

Model legislation to provide for living wills has been prepared for introduction by the Association for Freedom to Die, but has yet to be sponsored. The legislation recognizes the right of terminal patients to refuse life-prolonging measures and releases health care personnel from criminal or civil liability when they withhold or withdraw those life-prolonging measures. Under the proposed legislation, health care personnel unwilling to comply with the living will of a patient must make reasonable effort to transfer the care of that patient to a physician or health care facility willing to do so. Ten other states currently

have living will legislation that addresses the same issues: Arkansas, California, Kansas, Idaho, Nevada, New Mexico, North Carolina, Oregon, Texas, and Washington. The OSMA Office of State Legislation is monitoring its progress.

HB 938 (Bara, D-Elyria) — MEDICAL STUDENT LOAN PROGRAM

HB 938, sponsored by Representative John Bara (D-Elyria), establishes a medical student loan program through the Ohio Student Loan Commission. Student loans would be conditioned on agreement by the student to practice in an area of the state designated as an area with a shortage of personal health services. Loans would be forgiven after five (5) years of such practice. HB 938 is before the House Education Committee.

HB 272 (Batchelder, R-Medina) — STATE VOLUNTARY CATASTROPHIC HEALTH INSURANCE

HB 273 creates a voluntary catastrophic illness insurance plan to reimburse participants for ninety percent (90%) of the nonreimbursed expenses over \$2,500 attributable to a single catastrophic illness. The bill would permit twenty-five percent (25%) of the premium paid to be a tax credit against Ohio State income tax liability. The bill remains in the House Insurance Committee.

(continued on page 157)



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¹ Tinkelman, D. G., Carroll, M. S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. *Medical Challenge* 10: 24-26, 1978.

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CONTRAINDICATIONS: Hypersensitivity to any of its components.

WARNINGS: Theophylline should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

arrhythmias may be worsened by theophylline.

Usage in Pregnancy: Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

Theophylline should not be administered concurrently with other xanthines.

Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

ADVERSE REACTIONS: Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea. **CNS:** headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. **Cardiovascular:** palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. **Respiratory:** tachypnea. **Renal:** diuresis, albuminuria. **Other:** hyperglycemia, inappropriate ADH

secretion.

Drug Interactions: Toxic synergism with ephedrine and other sympathomimetic bronchodilators may occur.

OVERDOSAGE Treatment:

- A. If potential oral overdose is established and seizure has not occurred: 1) Induce vomiting. 2) Administer a cathartic. 3) Administer activated charcoal.
- B. If patient is having a seizure: 1) Establish an airway. 2) Administer O₂. 3) Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg. 4) Monitor vital signs, maintain blood pressure and provide adequate hydration.
- C. Post-seizure coma: 1) Maintain airway and oxygenation. 2) If a result of oral medication, follow above recommendations to prevent absorption of drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube. 3) Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as to not warrant consideration of dialysis.

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SB 253 (Zimmers, D-Dayton) — CHILD PROTECTION IN MOTOR VEHICLES

This bill creates a criminal offense for anyone who fails to use car seats, seat belts, and similar protective devices when transporting children under four years of age. The bill is now in the House Highways and Highway Safety Committee. The OSMA has no position on the bill.

SB 209 (Roberto, D-Ravenna) — CONVULSIVE THERAPY PROCEDURES

The bill changes procedures for administering convulsive therapy to mentally ill patients who are unable to consent. SB 209, actively supported by the OSMA, is in the House Judiciary Committee.

SB 200 (Stano, D-Parma) — NURSING HOME COMMISSION REPORT

SB 200 is one result of the Final Report of the Nursing Home Commission. The bill makes nursing home operators liable for damages to any patient who is injured or adversely affected by uncorrected violations of state health or safety standards in a nursing home. Suit may be brought by the patients themselves, by a sponsor of a patient, a patient's rights advocate, or the Attorney General. Patients' attorneys' fees will be paid by the state.

SB 62 (Valiquette, D-Toledo) — PRIVACY LAW AND MEDICAL RECORDS

SB 62 amends the state "Privacy Law" to exclude medical records from the definition of "public records," which are open for public inspection. The law overrules a 1978 Ohio Supreme Court case that held medical records were not excluded when maintained at a governmental facility. The law became effective in January, 1980.

HB 108 (Christman, D-Englewood) — NURSING HOME LICENSURE

HB 108 creates a state office of Inspector General of Nursing Homes responsible for regulating, licensing, and inspecting nursing homes. In addition, the legislation permits nursing home residents or the Attorney General to recover damages for violation of licensing standards or other violations of the law. The legislation is an extension of the work of the Nursing Home Commission. HB 108 is now in the House Rules Committee.

HB 210/211 (Brown, D-Columbus) — PROPOSED PHYSICAL THERAPY LEGISLATION

These two bills are part of a series of bills sponsored by Representative Les Brown (D-Columbus). HB 210 requires hospitals to accept and review applications for staff membership and/or practice privileges of physical therapists. HB 211 permits physical therapists to form professional corporations and potentially would prohibit physicians and hospitals from providing physical therapy services. Other bills, drafted but not introduced, would eliminate the existing statutory requirement for physician referral on prescriptions prior to physical therapists pro-

viding their services. The OSMA opposes both bills which are in a subcommittee of the House Small and General Business Committee.

HB 244 (Mahnic, D-Garfield Heights) — REINSTATES MOTORCYCLE HELMET REQUIREMENTS

HB 244 would reinstate the requirement that motorcycle and snowmobile operators and passengers wear helmets. The requirement was removed last session over the objection of the OSMA. HB 244 was amended to include motorcycle education requirements similar to those included in HB 143. HB 244 has been reported by the House Transportation and Urban Affairs Committee and is in the House Rules Committee. The OSMA strongly supports this legislation.

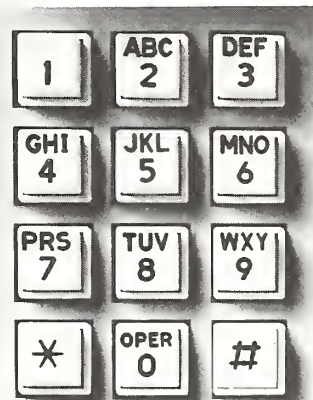
HB 415 (Lehman, D-Cleveland) — REMOVAL OF CORNEA FOR TRANSPLANTS

HB 415 permits the removal of donor eyes for corneal transplants and other medical or research purposes from bodies which a county coroner autopsies. The legislation requires the State Medical Board to establish a training program in the removal of eyes. HB 415, supported by the OSMA, is effective this month.

HB 470 (Panehal, D-Cleveland) — ALCOHOL REHABILITATION AND EDUCATION

HB 470 requires an increase in liquor permit fees and appropriates the increase for alcoholism education and rehabilitation programs. The bill has passed both chambers, and was signed into law October of 1979.

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Medical Education in Ohio

Part III Continuing Medical Education

Howard S. Madigan, M.D.

Continuing Medical Education (CME) has been a focus of attention during the 1970s by a number of special interest groups, including educators, lawyers, legislatures, and the public. The cumulative effects of this attention have impacted on CME in a variety of ways, some beneficial, others adverse. This third article in the series of Medical Education in Ohio will: (1) review changes and developments during the past decade, from a national perspective and with respect to Ohio; (2) discuss the current status of CME in Ohio; and (3) describe some goals and prospects for the future of CME.

Review

The concept of medical education as a continuum, ie, undergraduate, graduate and continuing education, gained momentum as a consequence of the Millis Report in 1965. However, emphasis was placed on the first two phases and the need to provide a satisfactory bridge between undergraduate and graduate education. The third phase, CME, was assumed as an integral part of physicians' professional lives. To an extent, this was a valid assumption. Traditionally, physicians recognize the need to keep up to date. They have fulfilled this responsibility through reading, discussion with colleagues, and attendance at local, regional, and national meetings. New developments and the increase in necessary knowledge, coupled with growing demands on physicians' practice time, impinge on the time and energy available for CME. Another impediment, until recent years, was the nebulous relationship between the providers of CME, ie, medical centers, professional societies, and practicing physicians. In effect, more CME was produced and promoted, without concern for the market. Resulting partially from the Regional Medical Programs effort in the late 1960s, specific attention was accorded CME and recognition of the need to respond effectively to the educational needs of practitioners was begun. At the community and regional levels, active roles in CME for the community hospital and the medical schools were delineated. Directors of medical education (DME) for community hospitals and CME departments/offices in medical schools were developed. Organizations such as the Association for Hospital Medical Education (AHME) and the Society of Medical College Directors of CME (SMCDCME) have evolved. Their purpose is to assist in further development of CME as an integral phase of medical education.

In the early 1970s, CME began to feel the impact of burgeoning medicolegal disputes and an accelerating incidence of malpractice litigation. An effect of these external

pressures was the enactment of legislation that mandated CME for physicians. In the minds of legal and other proponents of legislation aimed at reducing the malpractice problem, mandating that physicians have CME and submit documentation as a requirement for reregistration of medical licensure would have a salutary effect on the problem. At present, 20 states, including Ohio, have mandatory CME requirements.

In Ohio, longstanding CME involvement by the OSMA was augmented in 1970 through establishment of a *Commission on Medical Education*. This expanded the OSMA Committee on Education to include representation by the Regional Medical Programs and, at that time, the four medical schools in Ohio. The Commission gave careful attention to a variety of health professional education issues and, in 1973, conducted a CME survey to identify current practices and future needs of Ohio physicians. In 1974, the OSMA was delegated by the AMA Council on Medical Education to conduct a voluntary CME Accreditation Program for Ohio and a Physician's Recognition Award Program paralleling that of the AMA. Both activities were initiated in 1975 prior to enactment of the mandatory CME legislation. To implement the CME provisions of the legislation, the Ohio State Medical Board accepted the OSMA program, enabling doctors to meet the Board's requirements by obtaining the AMA or OSMA Physician's Recognition Award.

CME in Ohio

The CME Accreditation Program for institutions/organizations in Ohio is conducted under the aegis of the OSMA Committee on Medical Education (formerly the Commission on Education). Since 1975, approximately 50 initial accreditation surveys have been made; many have been resurveyed for continued accreditation. Table 1 lists the hospitals and organizations currently accredited (December 1979) in each of the six Education Regions

(continued on page 160)

as defined by the Ohio Board of Regents. In addition, medical schools and a few institutions/organizations accredited by the AMA or the Liaison Committee on Continuing Medical Education (LCCME) are identified by an asterisk.

The accreditation of these intrastate facilities makes continuing education opportunities readily available and accessible to practicing physicians, and enables them to meet State Medical Board CME requirements. Similar accreditation programs in other states requiring mandatory CME, serve to overcome some of the educational, economic, and time-related impediments to CME participation.

From an *educational* viewpoint, these changes of the past decade have provided several stimuli. They make CME educationally sound, responsive to doctors' needs, relevant to their practice, and help achieve a demonstrable relationship between CME and the quality of patient care. Progress toward these goals is being mediated effectively through medical education coordinators/directors and hospital staffs. Thus, identification of CME needs based on patient care audit and other accepted methods, followed by well-planned programs with appropriate evaluation, have become conventional. At the local level, this type of CME is valuable to the physician in practice. Development of an educational environment and suitable resources for other forms of CME, eg, self-directed learning, is conducive to more active participation. There is commitment by the medical schools to support and supplement community and regional CME activities. Each is engaged in outreach efforts, for example, faculty members conduct programs in response to perceived or demonstrated needs identified by the local medical staff; and programs are presented upon request for local and county medical or specialty societies. A variety of conferences, seminars, and symposia also are offered by the medical schools.

Hospitals throughout Ohio, as indicated in Table 1, are participating actively in CME. Impressive are the efforts by small/medium-size hospitals which have comparatively fewer physicians on their staffs. Usually under the guidance of a volunteer or part-time DME, the necessary personnel and other resources have been mobilized and organized to develop a CME program that meets accreditation standards. In some instances, innovative approaches to in-house CME have evolved. Coupled with judicious use of visiting faculty from the medical school in the region and other outside sources, valuable CME programs of good quality are available.

The CME programs in larger hospitals often reflect the departmentalization which is characteristic of these institutions. In some, there may be departmental education directors in addition to an overall DME. Departmental directors frequently are responsible for the graduate medical education program. Occasionally, this results in lack/loss of identity of the CME component. However, CME programs generally are strengthened by the co-existence of residency programs and medical student teaching in the larger hospitals. Faculty and other resources available at the medical schools and hospitals offer

good CME opportunities on campus and through outreach activities.

One facet of CME that is receiving well-deserved attention is *needs assessment*, ie, determining physicians' CME needs, rather than the traditional pattern of offering a variety of programs which may or may not be germane to their needs. This activity tends to involve physicians more actively in their continuing education. Further, it fosters individual learning whereby the physician can proceed at his/her own pace using methodologies that are personally effective.

The OSMA Committee on Education provides assistance to DMEs and other CME leaders through periodic conferences and workshops. They are designed to focus on specific aspects of the CME process, eg, needs assessment, preparing educational objectives, program planning, and evaluation. Also, workshops regarding the CME accreditation process are conducted for hospital CME leaders and accreditation surveyors. These programs facilitate a sharing of information and expertise among the institutions/organizations throughout the State.

The Future

Increasingly, the validity of the mandatory CME concept is being questioned. However, it is unlikely that existing statutes will be repealed in the near future. It is incumbent upon those responsible for planning and implementing CME activities to insure educational quality, relevance to physicians' needs, and ultimately, benefit to patient care. Several future developments in CME may be anticipated:

- Revision of the category system presently used to identify creditable CME is needed. The system, which was developed for the American Medical Association's Physician Recognition Award (PRA), has been adopted by many states and specialty groups to help documentation of CME participation. The multiple-category system is cumbersome and, with few exceptions, only serves to indicate that the physician was engaged in the activity for a specified number of hours. Consideration is being given by the AMA Advisory Committee on CME to development of a single category which would be used for the PRA.

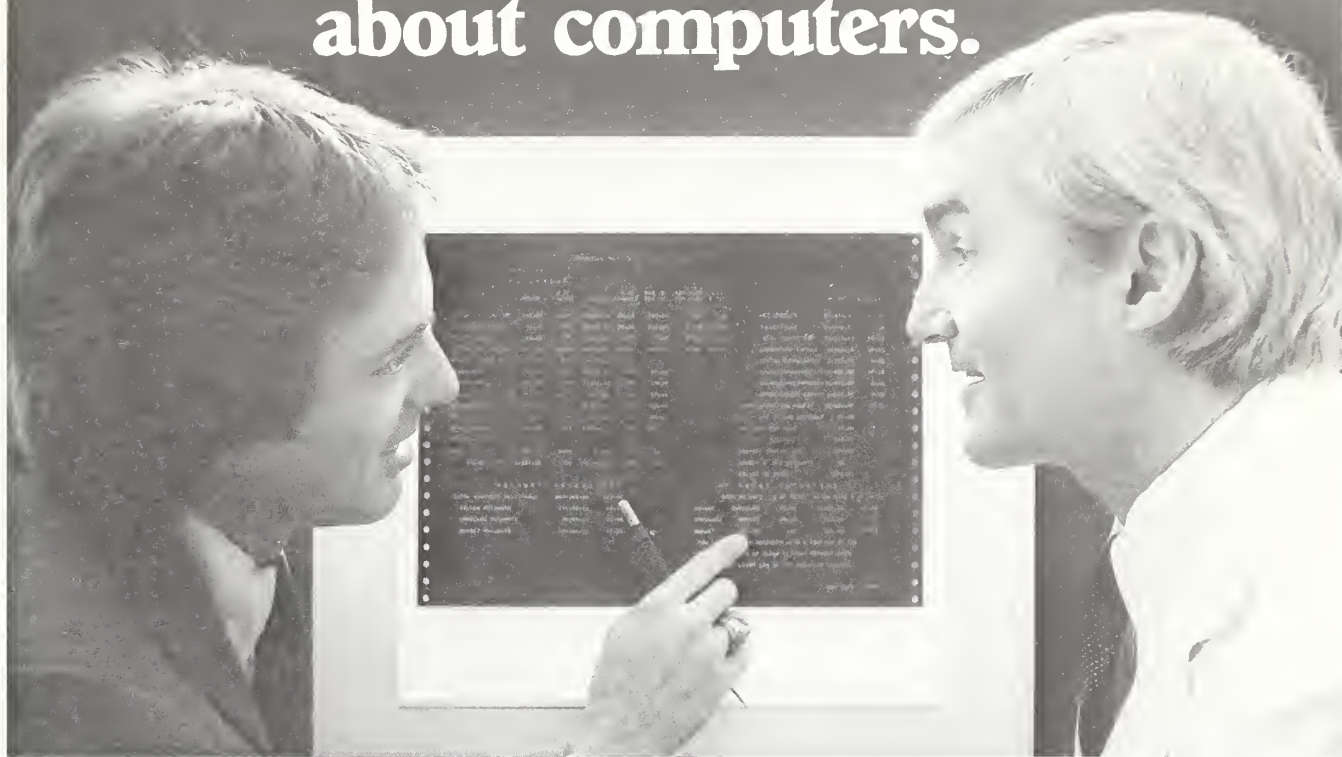
- Although significant progress has been made, further efforts are needed to improve the educational quality of CME. This involves attention to the education process as it applies to practicing physicians participating in CME, including effective teaching/learning modalities, active participation methods, and evaluation of learning. Greater emphasis will be placed on self-directed learning technics.

- Increased efficiency and economy of CME are becoming necessary. Legislative mandates, specialty society requirements and growing demands for physicians' services are likely to continue. Hence, the time, effort, and money expended for CME must be cost effective and personally economical.

- In many instances the role of the community hos-

(continued on page 162)

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pital as a prime CME resource will continue and be expanded. Also, medical school CME activities, particularly outreach programs mediated through the Area Health Education Center Programs, will serve to enhance accessibility and availability of CME.

Other changes may occur, some resulting from additional (hopefully less) government regulation and others in conjunction with specialty certification/recertification requirements. It is essential that providers of CME, including practicing physicians and the community hospital/medical school, collaborate effectively to achieve the desired quality of education that offers optimal opportunity to benefit patient care.

Summary

Continuing medical education, an integral part of the continuum of medical education, has been thrust into a position of singular importance, primarily resulting from efforts by external groups. One beneficial effect has been to stimulate DMEs and other medical educators to improve the quality of CME. Through the accreditation process, the availability and accessibility of CME have been increased substantially.

Now and in the future, physicians have a more well-defined, active role in their continuing education. New and/or different teaching-learning modalities will facilitate this. The goal of evaluating the effectiveness of CME on the care of patients is achievable and represents a

major challenge in the field of continuing medical education.

In Ohio, ongoing activities and those in various stages of development, eg, the AHEC program, augur well for the future of CME.

TABLE 1

Institutions/Organizations in Ohio Accredited for CME

Region I — Medical College of Ohio

Blanchard Valley Hospital	Findlay
Lima Area Medical Education Development, Inc.	Lima
*Medical College of Ohio and Associated Hospitals	Toledo
Riverside Hospital	Toledo
St. Luke's Hospital	Maumee

Region II — Case Western Reserve University School of Medicine

*American Broncho-Esophagological Association	Cleveland
*American Electroencephalographic Society	Willoughby Hills
*Case Western Reserve School of Medicine	Cleveland
Cleveland Clinic Educational Foundation	Cleveland
Hillcrest Hospital	Mayfield Heights
Huron Road Hospital	Cleveland
*International Anesthesia Research Society	Cleveland
Lakewood Hospital	Lakewood
Lutheran Medical Center	Cleveland
Nuclear Medicine Institute	Cleveland
*Ohio Valley Society for Plastic and Reconstructive Surgery	Cleveland
St. John Hospital	Cleveland
St. Joseph Hospital/Community Hospital Consortium	Lorain

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Region III — Northeastern Ohio Universities

College of Medicine

Akron City Hospital	Akron
Akron General Medical Center	Akron
Aultman Hospital	Canton
The Children's Hospital of Akron	Akron
Mahoning Shenango Area	
Health Education Network	Youngstown
Robinson Memorial Hospital	Ravenna
St. Thomas Hospital	Akron
Timken Mercy Hospital	Canton

Region IV — Wright State University School of Medicine

Children's Medical Center	Dayton
Community Hospital of Springfield and Clark County	Springfield
Dettmer Hospital, Inc.	Troy
Good Samaritan Hospital	Dayton
Greene Memorial Hospital, Inc.	Xenia
Kettering Medical Center	Kettering
Mercy Medical Center	Springfield
Miami Valley Hospital	Dayton
St. Elizabeth Medical Center	Dayton
Veterans Administration Center	Dayton
U.S. Air Force Medical Center	Dayton
*Wright State University, School of Medicine	Dayton

Region V — Ohio State University/Ohio University

College of Medicine/College of Osteopathic Medicine

American Heart Association, Central Ohio Chapter	
Bethesda Hospital	Columbus
Children's Hospital	Zanesville
Community Medcenter Hospital	Columbus
	Marion

Good Samaritan Medical Center	Zanesville
Grant Hospital	Columbus
Harding Hospital	Worthington
Licking Memorial Hospital	Newark
Memorial Hospital of Union County	Marysville
Mount Carmel Medical Center	Columbus
Ohio Academy of Family Physicians	Columbus
*Ohio State Medical Association (Committee on Scientific Work)	Columbus
*Ohio State University, Center for Continuing Medical Education	Columbus
Ohio Thoracic Society	Columbus
Riverside Methodist Hospital	Columbus
St. Anthony Hospital	Columbus
Veterans Administration Hospital	Chillicothe

Region VI — University of Cincinnati College of Medicine

Butler County Medical Consortium	Hamilton
The Christ Hospital	Cincinnati
*University of Cincinnati College of Medicine	Cincinnati
Good Samaritan Hospital	Cincinnati

*Indicates institutions/organizations accredited nationally (figures submitted December 1979).

References available upon request.

Dr. Madigan, Associate Dean for Continuing Education at the Medical College of Ohio (Toledo), is a member of the OSMA Committee on Medical Education. He also serves on the AMA Advisory Committee on Continuing Medical Education and the Advisory Board of the Ohio AHEC Program.

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A Practical Approach to Management of Chronic Arterial Insufficiency of Lower Extremities

Bhagwan Satiani, M.D.

Intermittent claudication usually is easily identified by a comprehensive history and physical evaluation and objective confirmation with noninvasive vascular laboratory examination. Arteriography is necessary only when surgery is indicated. Dietary control, cessation of tobacco, and a well-regulated exercise program are important in the nonsurgical management. Where surgical reconstruction is required, the results are excellent. Newer modalities in Doppler testing have made the diagnosis, qualitative assessment, and follow-up of patients with claudication much easier.

ARTERIOSCLEROSIS IS A DIFFUSE, generalized disorder which tends to produce areas of segmental disease especially at the bifurcations of major arteries, for example, aortic bifurcation, femoral profunda division, and popliteal trifurcation. The symptoms produced by peripheral arterial occlusive disease are those of "intermittent claudication." Symptoms due to very severe end-stage occlusive disease consist of pain at rest, ulceration, and gangrene. Intermittent claudication is basically pain-produced by ischemic muscle during exercise. At this time blood flow requirements by the various muscle groups are increased five to tenfold and patients develop aching, cramping, and heaviness when the metabolic needs are not met due to the arterial stenosis. The

characteristic symptoms in the legs occur in the calf, thigh, or buttocks, and usually are produced at the same distance each time. However, as the disease advances, the claudication distance will become progressively shorter. The discomfort or pain is typically relieved by resting a few minutes and recurs again on walking or climbing stairs. Impotence in the male patient, along with hip or thigh claudication, occurs as a result of aortic bifurcation disease and constitutes the Leriche syndrome. Claudication generally can be classified according to its severity. In most cases, "severe" implies inability to walk one city block, "moderate," inability to walk one to two blocks, and "mild," ability to walk two or three blocks or more. Anatomically, arterial lesions that produce intermittent claudication usually fall into one of several categories: (1) occlusive lesions of the abdominal aorta and iliac arteries; (2) superficial femoral artery occlusive lesions; (3) combination of 1 and 2; (4) popliteal or distal tibial artery occlusion; and (5) various combinations of 1, 2, 3, and 4. Mild claudication usually is a result of obstruction or stenosis at one of these sites, usually the superficial femoral artery. Moderately severe claudication generally results from the presence of lesions at two or more of these areas and the presence of rest pain, gangrene, or ulceration usually implies two or three levels of arterial disease.

Pathogenesis

Current research on the pathogenesis of arteriosclerosis has concentrated on the composition of the arterial wall and the role of serum lipoproteins, smooth muscle cells, and problems with the metabolism of cholesterol at the cellular level. High- and low-density lipoproteins appear to have the opposite effect on arterio-

(continued on page 167)

Dr. Satiani, Columbus, Program Director in Peripheral Vascular Surgery, Grant Hospital; Attending Surgeon, Grant and St. Anthony Hospitals; and Clinical Instructor in Surgery, The Ohio State University College of Medicine. Reprint requests to 300 East Town Street, Baldwin Towers Suite 613, Columbus, Ohio 43215 (Dr. Satiani).

Submitted September 10, 1979.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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sclerosis. A high level of high-density lipoproteins seems to protect against arteriosclerosis obliterans, whereas increased levels of low-density lipoproteins such as Type IIA hyperlipoproteinemia correlates with the early onset of arteriosclerosis. Phospholipids, cholesterol, and cholesterol esters deposit in the intima of the arterial wall and set the stage for progressive arteriosclerosis. Regression of the initial process (fatty streaks) has been noted to a small extent in some primates upon withdrawal of the atherogenic stimulus, but at present no hard data exist to suggest that advanced lesions can be reversed. Diabetes mellitus frequently is seen in patients with arteriosclerosis and arterial occlusive disease is known to occur at an earlier age in diabetics. Typically, the smaller arteries, ie, below the knee blood vessels, are involved in diabetes more often than the larger arteries. Several authors have reported an association between hypertension and arteriosclerosis. Although the anatomic consequences of hypertension primarily involve the arterioles, hypertensive men have been noted to have slightly more aortic and iliac atherosclerosis than age-matched controls; hypertensive women, on the other hand, have an increased tendency toward arteriosclerosis in almost all the vessels. An increased incidence of obesity in patients with arteriosclerosis has not been noticed, but reduction in excess weight obviously will enable these patients to experience symptomatic relief from claudication.

Clinical Examination

Careful inspection of the extremities first is performed. Absence of hair, transverse ridging of the nails, and cracked shiny-appearing skin all indicate arterial occlusive disease. Palpation of the extremities consists of noting the temperature and moisture of the skin and nature of the capillary refill over the fingertips and toes. All peripheral pulses, including the carotid and brachial are noted. Blood pressure is measured in both arms, a difference between the two suggesting the presence of obstruction at the origin of the subclavian arteries, thereby indicating diffuse arteriosclerosis. A uniform system for recording pulses is necessary, such as 0 for absent pulses, 1+ for weak or diminished pulsations, and 2+ for normal pulses. With the patient in a supine position, both lower extremities then are elevated to approximately 45 degrees and held there for a few minutes. The patient may be asked to push against the examiner's hands. Normally, the pink color will remain in the toes and heels in spite of the elevation. In patients with moderate to severe arterial ischemia, elevation will cause the feet to blanch and sometimes assume a white, cadaveric color. Next, the patient is permitted to sit with the legs in a dependent position. The appearance of the veins and the skin color over the feet then is noted. Slow venous filling and a delay in return of normal color indicate arterial ischemia. If the feet become dark red (dependent rubor) this suggests maximum dilatation of skin capillaries, prolonged stasis of red cells due to slow arterial inflow, and indicates fairly advanced ischemia. If the history is suggestive of claudication but normal pulses

are felt, peripheral pulses are palpated after exercise. In patients with claudication it obviously is important to palpate all major peripheral arteries, including the abdominal aorta, for any evidence of aneurysmal disease. Auscultation then is routinely performed over the abdomen, both groins, and over the carotid region. The intensity and radiation of the bruits are noted.

Management

Nonsurgical management of patients with intermittent claudication is fairly straightforward. Vasodilator drugs frequently are used for patients with arterial occlusive disease, but no conclusive scientific data exists showing their effectiveness. No study exists demonstrating an increase in muscle flow in an ischemic limb above that obtained by exercise. Coffman and Mannick evaluated a few vasodilating drugs at rest and after exercise in patients with claudication.¹ No beneficial effect of the drug was seen. What is obviously needed is a prospective, double-blind study of patients treated with vasodilators versus exercise.

Smoking

There is a well-recognized association between smoking and arteriosclerosis. Intermittent claudication is influenced by tobacco as shown by Coffman² and the Framingham study.³ These studies showed that the rate of occurrence of intermittent claudication was twice as great among cigarette smokers as nonsmokers, and this increased with the intensity of the habit. Since carbon monoxide is present in tobacco smoke in a concentration of about 4%, measurement of carboxy hemoglobin can be used as a measure of tobacco smoke absorption. Wald, et al found that carboxy hemoglobin levels were significantly associated with intermittent claudication even allowing for age, smoking history, serum cholesterol, etc.⁴ A person with a level of 5% or more was 21 times more likely to be affected by claudication or ischemic heart disease as compared to a person of the same age, sex, and smoking habits, but a level less than 3%. It also has been shown that men (40-49 years of age) who smoke 40 cigarettes a day have five times the risk of dying from ischemic heart disease as compared to nonsmokers. The occlusion rate of prosthetic grafts implanted for arterial occlusive disease over the long term is much higher in smokers than in nonsmokers. As a corollary to this, the amputation rate is higher in patients with arteriosclerosis who continue to smoke. Therefore, it is important to ask patients with arteriosclerosis to abstain from tobacco in any form.

Dietary

Therapy should be directed against identifying the type of hyperlipoproteinemia, especially in younger patients. In the common type (Type IV) reduction of dietary cholesterol and correction of abnormal carbo-

(continued on page 168)

hydrate metabolism is helpful. Since isolated femoropopliteal disease usually is treated nonsurgically and this is closely associated with Type IV hyperlipoproteinemia, dietary advice is recommended. Reduction of excess weight in obese patients obviously will improve claudication to some degree. Treatment of diabetes in these patients is no different, but foot care is of utmost importance. Minor foot trauma, fungal infections, blisters from new shoes, and exposure to cold or heat, often lead to progressive infection and gangrene in diabetic patients with arterial occlusions, if not treated early. Anticoagulants currently are not used for treatment of chronic arterial occlusive disease in the form of claudication.

Exercise Program

The cheapest method available for the treatment of mild to moderate claudication is a well-regulated exercise program involving walking increasing distances. It has been demonstrated that walking improves muscular flow in the legs and the claudication distance is progressively increased. This occurs as a result of improved collateral circulation. Patients are instructed to walk through the aching experience at the onset of claudication, as the pain itself is not physically harmful. The walking distance then is increased gradually every day. In treating office patients for mild to moderate claudication, or postoperative patients, repeated arteriography is obviously painful, expensive, and unnecessary. Also, anatomic disease does not always correspond with the actual functional state of the limb. Recent technology has made available to the vascular surgeon a variety of instruments designed to assess the actual functional state of the extremity. Repeated testing with Doppler ultrasound technics is noninvasive, painless, less expensive, portable, and can be repeated as often as necessary (Fig. 1). The usual arterial testing performed in our laboratory includes waveform analysis, segmental Doppler pressure measurements (Fig. 2), and posttreadmill exercise pressure recordings. Measurement of blood pressure in the various vessels at rest and following exercise is an objective method of documenting the presence of arterial occlusive disease and quantitating the severity of disease. The differential diagnosis of leg pain thus becomes relatively easy. It is essential in patients with claudication who are being followed nonoperatively as well as in assessing the immediate and late result following arterial reconstruction. In the lower extremity the most useful measurement is the ankle systolic blood pressure determined by a Doppler. This pressure is then divided by the brachial systolic blood pressure to give an ankle brachial systolic index. This is normally in the range of 1.0.

Surgical Management

Because of the rare limb loss associated with surgical treatment of isolated segmental lesions, and the fact that some studies have suggested a retardant effect

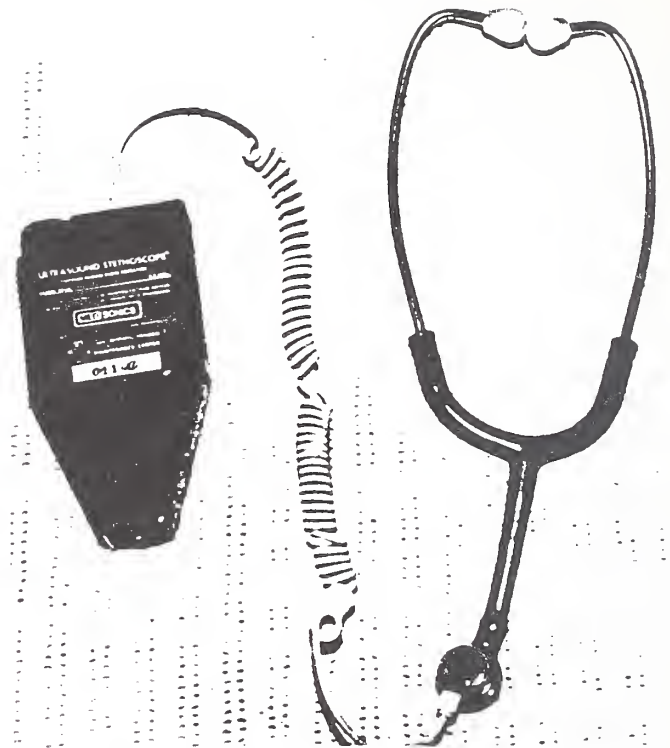


Fig. 1. Pocket Doppler ultrasonic stethoscope.

of such a lesion on the progression of distal arteriosclerosis, stricter criteria for operations have been established. Barring progression, a policy of waiting three to six months for a trial of nonsurgical treatment prior to operation is justified. If the patient continues to be unable to live with his or her disability, at that time angiography and surgical treatment are recommended. Obviously, the decision for or against operation has to be made with socioeconomic factors in mind. An otherwise healthy 50-year-old factory worker who is involved in heavy physical work on the job, suffers from considerable disability with even moderate claudication, and may be a surgical candidate sooner than usual. In contrast, a retired 65-year-old clerk with claudication of one or two blocks probably would be placed on an exercise program, with frequent noninvasive testing and reconstruction offered only if progression occurs or an increase in physical activity is desired.

Arteriography is performed when arterial reconstruction is planned; when the symptoms and the objective findings do not fit and the noninvasive tests are equivocal; or when another diagnostic entity such as associated aneurysmal disease is suspected. Incidental lesions seen on arteriography that are asymptomatic or incompatible with the patient's symptoms and signs are

SEGMENTAL SYSTOLIC PRESSURE

	RIGHT	LEFT
ARM	116	116
UPPER THIGH	—	—
ABOVE KNEE	130	120
BELOW KNEE	120	74
ANKLE	114	54
INDEX	.98	.46
POST EXERCISE	142	32

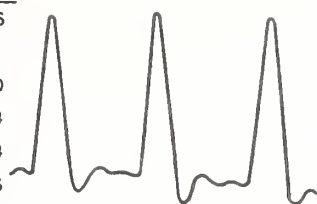


Fig. 2. Lower extremity noninvasive arterial tests of a patient with claudication in the left leg. The segmental pressures are markedly decreased below the knee on the left side with an ankle index of 0.46, indicating moderately severe arterial occlusive disease.

not by themselves an indication for surgery. The best results for long-term relief of claudication are obtained in patients with lesions confined to the aorto-iliac system. Aorto-femoral dacron bypasses carry an operative mortality rate of approximately 5% and have a patency rate approaching 85% at five years. Patients with combined aorta-iliac and femoro-popliteal occlusive disease currently are treated by aorto-femoral bypass as this often will totally relieve or reduce symptoms in spite of downstream femoro-popliteal or tibial artery occlusive disease. This is because an open profunda femoris artery provides enough collateral blood flow around the blocked superficial femoral artery. In patients with disease localized to the aorta and proximal iliac arteries, an endarterectomy often is sufficient to open up the blockage and restore patency without the use of prosthetic grafts. Reversed saphenous vein is the preferred material of choice for bypass of symptomatic femoro-popliteal occlusions. If the vein is small and diseased or has been previously used, various prosthetic materials are available. If the bypass can be performed to the popliteal artery proximal to the knee joint, prosthetics such as Goretex® (expanded polytetrafluorethylene), the Dardik® graft (glutaraldehyde-treated human umbilical vein), or dacron grafts, alone or in combinations, can be used. Patency rates with the new Goretex® graft appear promising. Other procedures performed concomitantly with either aorto-femoral or femoro-popliteal bypass include profunda-plasty and lumbar sympathectomy. In poor risk patients with severe disabling claudication, extra-anatomic reconstruction for unilateral or bilateral aorto-iliac disease can be performed with a lower mortality and morbidity rate. An axillary to femoral artery or a cross-femoral artery (across the pubis) subcutaneous bypass with an arterial prosthesis can be performed under general or

local anesthesia. Long-term results are good and five-year patency rates are respectable.

Prognosis

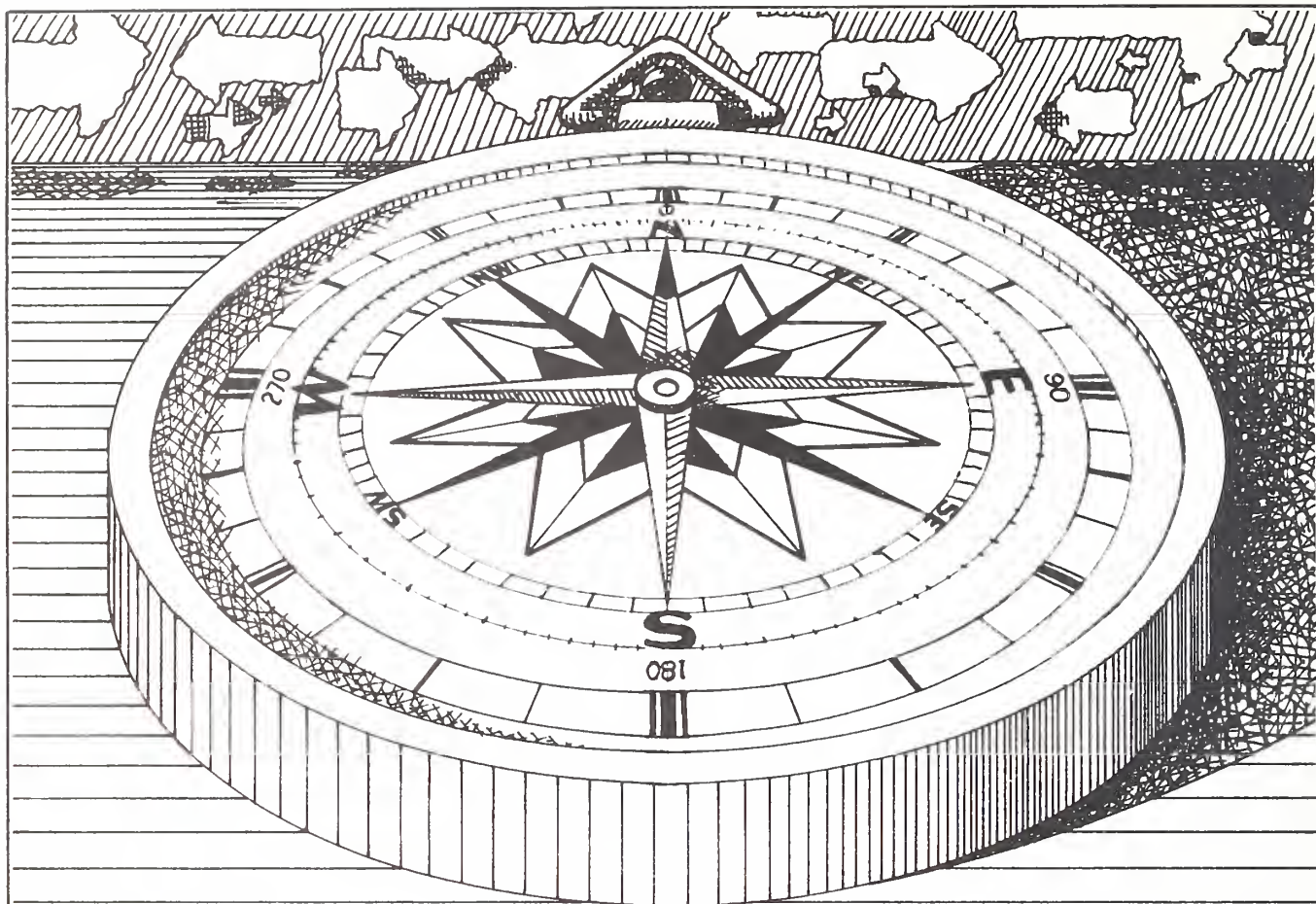
The natural history of untreated arterial occlusive disease has been studied. It is clear that *stable* and *mild* intermittent claudication resulting from either femoro-popliteal or aorto-iliac occlusive disease alone, is relatively benign if no rest pain, ulcers, or gangrene exists. The classic study is by Boyd, who treated 1,440 patients with mild intermittent claudication.⁵ The amputation rate was only 7% at the end of five years and 12% at the end of 12 years. As expected, a fair number of these patients had nonfatal coronary or cerebrovascular episodes. This report emphasized that patients even with segmental localized disease have asymptomatic generalized arteriosclerosis and the mortality from events unrelated to claudication, ie, stroke, myocardial infarction, is somewhat high. In a recent report, Imparato and colleagues reported a study of 104 patients with claudication who had angiography performed and were treated for as long as eight years.⁶ Deterioration was noted in 21% of patients, most of whom underwent surgery, whereas 79% remained stable. Of the latter group, 21% later underwent elective surgery, whereas the remainder continued on an exercise program. However, in the face of severe claudication, rest pain, ulcers, or gangrene, the need for surgical reconstruction is clear. Even the patient who is in poor medical condition can be revascularized with subcutaneous bypasses under local anesthesia.

Summary

Intermittent claudication is a manifestation of arterial insufficiency of the extremities. Severity of the disease and the level of involvement can be ascertained by sophisticated technics of Doppler pressure measurements. The need for surgical reconstruction is based on the extent of disability, the progression of disease, and the threat of limb loss. Results following reconstruction are extremely satisfactory and usually long lasting.

References

1. Coffman JD, Mannick JA: Failure of vasodilator drugs in arteriosclerosis obliterans. *Ann Intern Med* 76:35-39, 1972.
2. Coffman JD, Javett SL: Blood flow in the human calf during tobacco smoking. *Circulation* 28:932-937, 1963.
3. Kannel WB, Skinner JJ Jr, Schwartz MJ, et al: Intermittent claudication. Incidence in the Framingham study. *Circulation* 41:875-883, 1970.
4. Wald N, Howard S, Smith PG, et al: Association between atherosclerotic diseases and carboxyhaemoglobin levels in tobacco smokers. *Br Med J* 1:761-765, 1973.
5. Boyd AM: The natural course of arteriosclerosis of the lower extremities. *Proc R Soc Med* 55:591-593, 1962.
6. Imparato AM, Kim GE, Davidson T, et al: Intermittent claudication: Its natural course. *Surgery* 78:795-799, 1975.



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Move Ahead With OSMA

Preliminary Schedule of Events 1980 OSMA Annual Meeting

Our Society Moves Ahead — 1980 is the theme chosen for the 1980 Ohio State Medical Association Annual Meeting. We are excited with the beginning of a new decade and, with this beginning, invite you to attend.

The Annual Meeting will be held in Cincinnati, Ohio at the Stouffer's Cincinnati Towers and the Cincinnati Convention Center, May 10-14.

Something new is planned for you— Monday evening, May 12, 5:00 to 6:30 PM— an "exhibit fair" provided by exhibitors will be a real departure from the traditional technical exhibits. This will give exhibitors the opportunity to market their products or services in a relaxed, fun-fair atmosphere. Strolling musicians and refreshments will add to the festivities. Plan to attend. Admittance will be by badge. This event will be held at Stouffer's Cincinnati Towers.

Have you been putting off a course in CPR? Don't delay— Basic Life Support will be offered on Saturday afternoon, May 10. The Advanced Life Support is a two-day course offered on Sunday, May 11, and continued on Monday, May 12. Certification in Basic Life Support is a prerequisite for the Advanced CPR Course.

Don't forget the importance of a well-trained office staff. Remember, they represent you and are a very im-

portant part in the physician-patient relationship. Your image is important. Several programs offered on Saturday, May 10, may be just what your support staff has been needing to attend. A program for the Office Manager— Team Building is designed for the physician's office supervisor. In addition, programs for the Telephone Manager and Medical Collection Management will be offered.

Postgraduate Courses on Electrolytes and Blood Gases; Scanning— Noninvasive Diagnosis; Computers in Your Practice; and Drug Therapeutics are several programs being offered. In addition to these, a multitude of subjects will be covered by virtually every specialty. This is your opportunity to attend.

The traditional Ohio Medical Political Action Committee (OMPAC) luncheon will be held on Tuesday, May 13.

Although this is a mere sampling of the many activities planned for the 1980 OSMA Annual Meeting, the April issue of the Journal will contain a more complete schedule of events. In addition, a preliminary program will be mailed to all OSMA members one month prior to the Annual Meeting.

Mark your calendars now— remember, *Our Society Moves Ahead* — 1980.

May 10 - 14, 1980, Cincinnati

Headquarters Hotel — Stouffer's Cincinnati Towers

Coheadquarters Hotel — Terrace Hilton

Scientific Meetings and Scientific Exhibits — Cincinnati Convention Center

Resource Center and Exhibit Fair — Stouffer's Cincinnati Towers

Saturday, May 10, 1980

Registration	7 AM — 1 PM
Basic Life Support	1 PM — 5 PM
Managing People & Money	1 PM — 5 PM

Medical Collection Management	1 PM — 4 PM
Office Manager — Team Building	8:30 AM — 4:30 PM
You — The Telephone Manager	9 AM — 12 PM

(continued on page 175)

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gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

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Advanced Life Support	8 AM — 6 PM
Media Training Seminar for Physicians	8:30 AM — 3 PM
OSMA Delegation to AMA	2 PM — 4 PM
House of Delegates	
Registration	3 PM — 7 PM
Buffet Dinner:	5:30 PM
Delegates, Alternates, OSMA Council, and Official Guests	
First Business Session	7 PM — 9 PM
Councilor District Caucuses	4 — 5:30 PM

Monday, May 12, 1980

Complimentary Buffet Breakfast	7 AM — 8 AM
Reference Committee Meetings	7:30 AM — 2 PM
Resolutions Committee 1	
Resolutions Committee 2	
Resolutions Committee 3	
President's Address	
Nominations	
General and Advance Registration	8:30 AM — 5 PM
Advanced Life Support	8 AM — 5 PM
Dermatology	9 AM — 12 NOON
Resource Center	10 AM — 2 PM
Otolaryngology	8:45 — 4:30 PM
Lunch	12 NOON
Ohio Health Commissioners	11 AM — 4 PM
Scientific Exhibits	9 AM — 4 PM
Rheumatology	
Lunch	12 NOON
Meeting	1 PM — 5 PM
Medicine and Nursing	2 PM — 4 PM
Ohio State Neurosurgical Business Meeting	5 PM — 6:30 PM
Exhibit Fair	5 PM — 6:30 PM

Tuesday, May 13, 1980

Postgraduate Courses	7:30 — 10:30 AM
Course 1: Electrolytes & Blood Gases	
Course 2: Scanning-Noninvasive Diagnosis	
OMPAC Board Breakfast	8 — 11 AM
General and Advance Registration	8:30 — 5 PM
Ohio Health Commissioners	9 AM — 4 PM
Pfizer Dialogue	9 AM — 4 PM
Scientific Exhibits	9 AM — 4 PM
Pathology	9 AM — 4:30 PM
Lunch	12:30 PM

Ohio Chapter, American Academy of Pediatrics	
Meeting	9 AM — 12 NOON
Lunch	12 NOON — 1 PM
Ohio Chapter, American College of Emergency Physicians	1:30 — 4:30 PM
Neurosurgery	9 AM — 5 PM
Lunch	12 NOON — 1 PM
Resource Center	10 AM — 2 PM
Sports Medicine Luncheon	12 NOON
Ophthalmology	1:30 — 5 PM
OMPAC Luncheon	11:30 AM — 2 PM
Reception & Luncheon	
Ohio Psychiatric Association	
Board of Directors	8 AM
Lunch	11:30 AM
Meeting	1 — 5 PM
Internal Medicine	9 AM — 12 NOON
OSMA Social Function	6:30 PM

Wednesday, May 14, 1980

Postgraduate Courses	7:30 — 10:30 AM
Course 1: Computers in Your Practice	
Course 2: Drug Therapeutics	
General and Advance Registration	8:30 AM — 5 PM
Ohio Committee on Trauma	9 AM — 12 NOON
Scientific Exhibits	9 AM — 4 PM
Ohio Health Commissioners	9 AM — 4 PM
Plastic Surgery	
Meeting	9 AM — 12 NOON
Lunch	12:15 PM
Resource Center	10 AM — 2 PM
Committee on Scientific Work	
Luncheon/Meeting	12 NOON
Anesthesiology	1:30 — 4:30 PM
Colon and Rectal Surgery	1:30 — 4:30 PM
Allergy and Immunology	8:30 AM — 12 NOON
House of Delegates	
Registration	2:30 — 3:30 PM
Final Business Session	3:30 — 6 PM
Buffet Dinner:	
Delegates, Alternates, OSMA Council and Official Guests	6 — 7 PM
Final Session	7 — 10 PM

Thursday, May 15, 1980

OSMA Council Meeting	8:30 — 10 AM
PICO Stockholders Meeting	10 AM — 12 NOON

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MARY A. AGNA, M.D., Dayton, became a Fellow of American Association of Family Practitioners.

HOMER A. ANDERSON, M.D., Columbus, was re-elected president of the board of trustees of the Medical Bureau. **JOHN N. MEAGHER, M.D.**, Columbus, was elected secretary-treasurer.

JAMES P. BADEN, M.D., is the 1980 chief of the medical and dental staff at Mercy Hospital North in Hamilton, Ohio.

Other officers of the committee are **KENNETH L. WEHR, M.D.**, chief of staff-elect; **RICHARD WILLIS, M.D.**, secretary; **J. MICHAEL DOLIBOIS, M.D.**, chief of surgery; **CHAD H. DUNKLE, M.D.**, chief of medicine; and **MIKOLA DOROCHOWICZ, M.D.**, chief of obstetrics and gynecology, Hamilton.

Recognition Awards for "Distinguished Personal and Professional Contributions" were presented to **KENNETH BEERS, M.D.**, **SHERMAN KOHN, M.D.**, **EVELYN MOBLEY, M.D.**, and **EDGAR REAGAN, M.D.**, Wright State University School of Medicine, Dayton.

NORMAN H. BLASS, M.D., Dayton, was appointed as consultant to the AMA's Advisory Panel on Electronic Fetal Monitoring.

E. C. BRANDT, M.D., Lancaster, and his wife Relda were feted by family and friends during a retirement dinner and program held in their honor. Dr. Brandt practiced medicine in Crestline for 53 years.

DUDLEY F. BRIGGS, M.D., Columbus, was elected Ohio's Delegate Director to the Board of the National Mental Health Association during its annual meeting in Denver.

HAROLD J. BRODELL, M.D., Warren, became the new president of Trumbull Memorial Hospital medical staff.

Other officers include **JOHN BIGGINS, M.D.**, vice president, and **J. O. VLAD, M.D.**, secretary-treasurer.

Elected chiefs of the hospital's various services were: **CORRADO SARTARELLI, M.D.**, surgery; **THOMAS JAMES, M.D.**, medicine; **R. P. BOLLESTEROS, M.D.**, obstetrics-gynecology; **M. D. SORRELL, M.D.**, pediatrics; **ENGLEBERT HECKER, M.D.**, radiology; **R. E. PENCE, M.D.**, pathology; and **DR. SUDIMACK**, family practice.

RICHARD P. BURKHARDT, M.D., Hamilton, is the 1980 chief of the medical and dental staff at Mercy Hospital South in Fairfield.

Other officers of the Committee are **THOMAS U. TODD, M.D.**, chief of staff-elect; **RICHARD ZETTLER, M.D.**, secretary; **FLAVIO AMONGER, M.D.**, chief of surgery; **BARRY W. WEBB, M.D.**, chief of medicine; **ROBERT J. LERER, M.D.**, chief of pediatrics; and **BRADY F. RANDOLPH, M.D.**, past chief of staff, Hamilton.

MILES BURKE, M.D., Hamilton, is the first full-time director of the pediatric ophthalmology department at Children's Hospital Medical Center, Cincinnati.

AFTAB BUTT, M.D., was certified by the American Board of Plastic and Reconstructive Surgery. **DONG LEE, M.D.**, Dayton, was certified by the American Board of Surgery.

JOHN J. CAHILL, M.D., Kirtland, was appointed to the board of directors of First Federal Savings and Loan Association of Willoughby.

OSMA staff member, **JERRY CAMPBELL**, Columbus, was elected president-elect of Professional Convention Management Association during its annual meeting in Kansas City.

Mr. Campbell, a graduate of Ohio State University, is an associate executive director of the Ohio State Medical Association. His duties include the management of several Ohio medical specialty societies and staffing of the Ohio delegation to the American Medical Association. In addition, he is a member of the board of directors of the Physicians Life Insurance Company.

Prior to his election, Mr. Campbell served as vice president of PCMA and as a member of various committees. He currently serves as a member of the PCMA board of directors and belongs to several professional societies.

He will assume the office of president at PCMA's annual meeting in January, 1981.

THEODORE J. CASTELE, M.D., Fairview Park, was re-elected director of radiology at Lutheran Medical Center.

The board of trustees of Greene Memorial Hospital, Dayton, approved for one-year terms as medical staff officers, vice chief of staff, **PRIVIKANT K. DESAI, M.D.**, and secretary, **RONALD TAYLOR, M.D.**

Also approved were two at-large members, **ALY A. GORRAFA, M.D.**, and **JOHN PETERANGELO, M.D.**, Dayton.

OSMA member **NICHOLAS J. GARRITANO, M.D.**, Youngstown, was recertified as a Diplomate of the American Academy of Family Practice.

(continued on page 180)

ROBERT T. GRAY, M.D., Marion, was elected council commissioner of the Harding Area Council, Boy Scouts of America.

SAMUEL GROSS, M.D., Moreland Hills, was elected vice-president of Children's Oncology Services of Northeastern Ohio, Inc.

THELMA LANGE HERWIG, M.D., was named a Diplomate of the American Board of Family Practice. **JAMES MASON, M.D.**, Upper Arlington, also was recertified.

ALAN R. KAMEN, M.D., Hartville, was installed as president of the Aultman Hospital medical staff. Other officers elected include: **V. T. MEHTA, M.D.**, Canton, president-elect and **ROBERT B. MILLER, M.D.**, Canton, secretary-treasurer.

DAVID KELLY, M.D., Dublin, was elected president of the American Cancer Society, Franklin County Unit Board of Directors.

EDWARD F. KIEGER II, M.D., Cleveland, was elected president-elect of St. Alexis Hospital.

GERALD KLEBANOFF, M.D., Boardman, was named chairman of the Committee on Operating Room Environment of the American College of Surgeons.

JOSEPH KOELLIKER, M.D., Willoughby, was selected "Doctor of the Year" by the staff of West End Hospital. **WILLIAM DOWNING, M.D.**, Painesville, also was given the same honor at Lake County Memorial Hospital.

RALPH D. LACH, M.D., Columbus, was elected president of Mt. Carmel Hospital's medical staff. **PAUL J. MATRIKA, M.D.**, was chosen president-elect and **PAUL T. MCGHEE** is the new secretary-treasurer.

DEAN LIMBERT, M.D., Youngstown, joined the advisory board of trustees of Planned Parenthood of Mahoning Valley, Inc., for a three-year term.

ROBERT MARKS, M.D., was elected Chief of Medicine at Lorain Community Hospital. **ROBERT WRIGHT, M.D.**, is the new Chief of Surgery and **THOMAS MARTIN, M.D.**, Lorain, Director of Medical Education.

The American Medical Association's 1980 Distinguished Service Award will be presented to **FRANK H. MAYFIELD, M.D.**, Cincinnati, during the AMA meeting in July.

Dr. Mayfield, a neurosurgeon, was chosen for the honor by the AMA House of Delegates during the 1979 Interim Meeting in Honolulu.

Dr. Mayfield is a former president of OSMA and former chairman of the Ohio Medical Political Action Committee. He was president of both the Society of Neurological Surgeons and the Harvey Cushing Society (American Assn. of Neurological Surgeons).

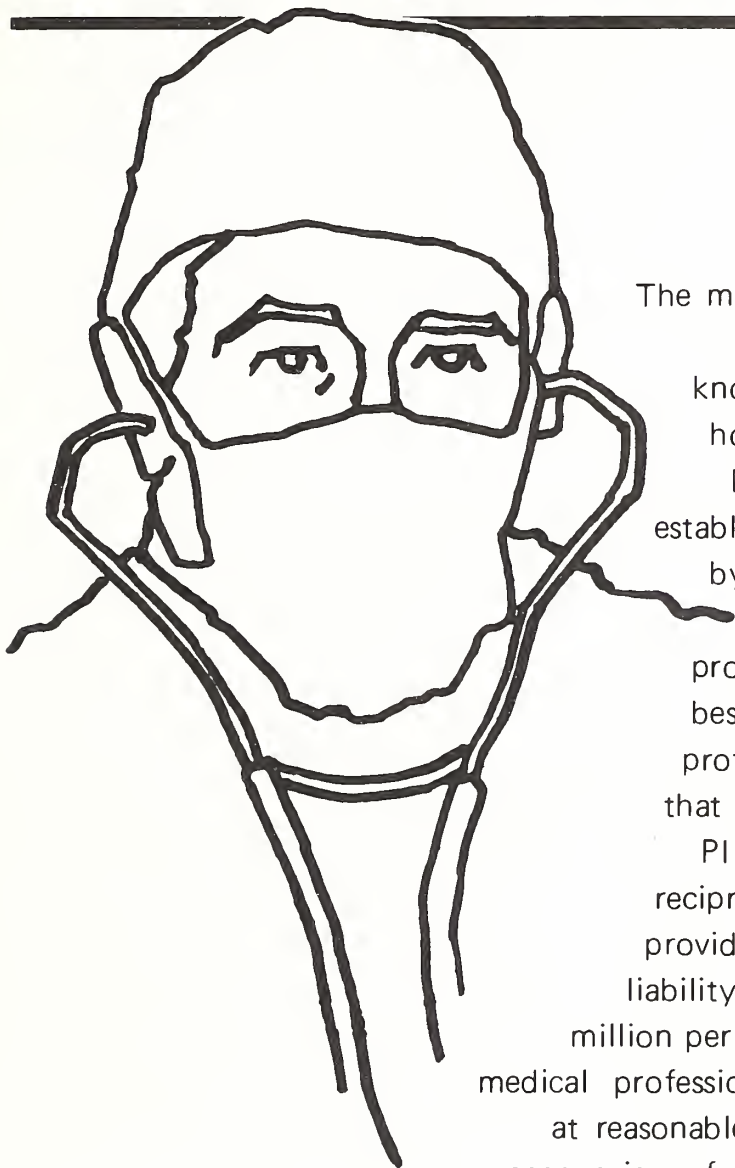
He was a member of the American College of Surgeons Board of Governors and chairman of the American Board of Neurological Surgery. An AMA delegate from 1971 to 1976, Dr. Mayfield was a member of the AMA interspecialty Advisory Board.

He received the American Board of Neurological Surgery's distinguished service award, and in 1977 he was the recipient of the Cushing Medal of the American Assn. of Neurological Surgeons.

ROBERT E. McARTOR, M.D., Salem, is the new director of the Family Practice Residency Training Program at St. Elizabeth Hospital Medical Center in Youngstown. In 1978, Dr. McArtor was chosen "teacher of the year" at West Side Family Practice Center of Akron General Medical Center.

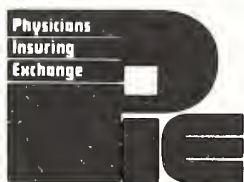
(continued on page 182)

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GLEN E. MILLER, M.D., Bellefontaine, was elected to the 12-member board of directors of the Menonite Board of Missions, Elkhart, Indiana.

JOHN PETER MINTON, M.D., Columbus, was selected by the Cancer Society as professor of clinical oncology for the State of Ohio.

Mahoning County Medical Society's "Doctor of the Year" (1979) award was presented to OSMA member **RICHARD D. MURRAY, M.D.**, Youngstown. In addition to being a plastic surgeon, Dr. Murray is an artist, author, and sculptor.

WALTER W. RANDOLPH, M.D., Fremont, was elected president of the Ohio Society of Pathologists for the 1979-1980 term. The Ohio Society of Pathologists was established in 1960 and represents over 300 pathologists.

RICHARD S. RICHARDS, M.D., Boardman, was elected secretary-treasurer of the clinical staff of St. Elizabeth Hospital Medical Center, Youngstown.

E. P. SCHAEFER, M.D., Salem, was elected president of the medical staff at Northern Columbiana County Community Hospital. **L. J. BUJDOSO, M.D.**, Lisbon, is the new vice president.

FRANCIS W. SHANE, M.D., Gallipolis, was honored as Gallia's Man of the Year by the Southeastern Ohio Regional Council. Dr. Shane ended 47 years of medical practice in Gallipolis and Gallia County on December 31, 1977. He served 44 years of that period as health commissioner for Gallia County.

During the 34th annual meeting of the American Cancer Society, Ohio Division, Inc., **VICTOR SIMIELE, M.D.**, Lancaster, was presented with the National Divisional Award. The award was given in recognition of Dr. Simiele's dedication to the cause of cancer control.

WILLIAM SINCLAIR, M.D., Fairview Park, was re-elected Director of Laboratory Medicine at Lutheran Medical Center, Westlake.

The Daniel L. Mausser Americanism Award was presented to OSMA member **MAXWELL UDELF**, Cleveland, by the American Legion's Excelsior Post 628. Dr. Udefl retired in 1978 after 42 years' practice as an eye specialist.

GEORGE WAYLONIS, M.D., Columbus, and **MILTON SENTOR, D.O.**, were interviewed by Erin Moriarty of CUBE system's "Columbus Alive" television program, regarding the differences and similarities between the two schools of medicine.

DAVID R. WEIR, M.D., Chagrin Falls, was honored as the recipient of the Hawken School "Carl N. Holmes Distinguished Alumnus Award." Dr. Weir retired last year as director of medicine at Highland View Hospital, a position he held since 1953.

The 29th Annual Scientific Session of the College will be held in Houston, March 9-13. **ARNOLD M. WEISSLER, M.D.**, Detroit (formerly Columbus) is chairman of the Scientific Program Committee and **RICHARD P. LEWIS, M.D.**, Columbus, is cochairman.

RANSOME R. WILLIAMS, M.D., Worthington, was recertified as a Diplomate of the American Board of Family Practice.

ROBERT A. WILTSIE, M.D., was named clinical associate dean of medical students from the Northeastern Ohio Universities College of Medicine.

WILLIAM B. WLADECKI, M.D., Elyria, was elected to the board of directors of First National Bank.

CHARLES F. WOOLEY, M.D., Columbus, American College of Cardiology Governor for Ohio, announced that **DAVID R. MARCUS, M.D.**, and **HANS J. J. ZWART, M.D., PH.D.**, Dayton, have achieved the ACC's membership rank of Fellowship.

PAUL ZEIT, M.D., Burton, will serve as vice-chairman of the Ohio State University Comprehensive Cancer Center in Columbus.

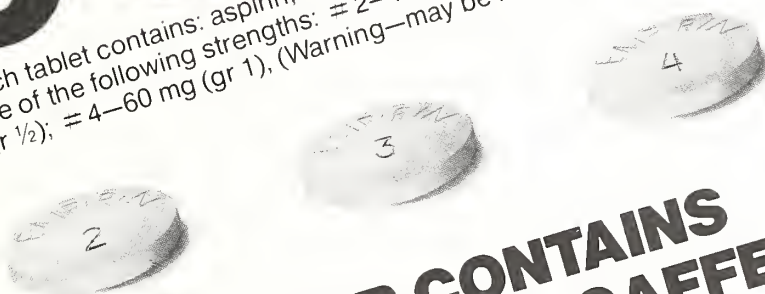
Certificates were presented to numerous OSMA members for their outstanding service to Aultum Hospital, Toledo, and the community. Those recognized include:

For 40 years service—**DRS. HAROLD J. BOWMAN, MARK G. HERBST, CLAIR B. KING**, and **RALPH T. WARBURTON**; 35 years—**DRS. ALBERT J. GILBERT, CARL A. LINCKE, SAMUEL S. REINGLASS**, and **MERLE WEAVER**; 30 years—**DRS. HERBERT A. JONES, JOHN C. McDONALD, THOMAS B. SHIPLEY, CLARENCE V. SMITH**, and **WILLIAM A. WHITE, JR.**; 25 years—**DRS. SAMUEL N. ABOOD, MELVIN W. HARRIS, WALTER H. KASSERMAN**, and **WILLIAM S. ROTHERMEL**; 20 years—**DR. STEVE E. KEISTER**; 15 years—**DRS. ANDREW BOTSCHNER, OMAR ELAZER**, and **JAMES R. WARD**.

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AAA Physicians Meet

The annual meeting of "International Doctors in Alcoholics Anonymous" will be held in Washington D.C., at the Hyatt-Regency on July 31 to August 3, 1980. Make hotel reservations directly with the Hyatt at 400 New Jersey Avenue, N.W., Washington D.C. 20001. For further information contact the Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio. Phone: 216/782-6216.

Suicide Rate Up

The number of physicians committing suicide is increasing, according to an article in the Huron Tribune, Michigan. An Arizona psychiatrist specializing in the problems of physicians, said that pressures currently are so intense at least 300 physician suicides are reported nationally every year. He also said at least 10% of all physicians suffer from untreated bouts with chronic depression, alcoholism, and drug dependence.

Dilemmas of the '80s

Dilemmas of the Decade— Medical Education and Licensure, is the theme of the 76th Congress on Medical Education being held in Chicago (Palmer House) April 24 to 26, 1980.

Newton Minow, former chairperson of the FCC, will speak on The Regulation of Medicine. Dr. Donald Kennedy, former commissioner of the FDA, will be the keynote speaker at the opening session.

Year 2000—Physician Supply Up

A 43% to 108% increase in the supply of physicians will occur through the year 2000, according to a discussion paper available through the AMA Center for Health Services Research and Development. The proportion of female physicians is estimated to increase from 9% to 13% of the total supply. If the mix of current specialty choices remains stable throughout the projection period, the smallest increases are projected for the specialties of general surgery and general/family practice.

Smoking and the Pill

Researchers in the Kaiser-Permanente Contraceptive Drug Study devised a Relative Risk scale to measure the impact of smoking on health. The results were: smokers have a relative risk of 2.9 for heart attacks, 5.7 for brain hemorrhage, 4.8 for other strokes, and 3.9 for blood clots. In oral contraceptive users who also smoked, relative risk of brain hemorrhage jumped to 21.9.

High blood pressure, high cholesterol, obesity, gallbladder disease, and nondrinking of alcohol were all associated with increased risk of heart attack, whereas only high blood pressure and high cholesterol were associated with increased risk of other strokes.

"Smoking should be considered a contraindication to oral contraceptive use, or at the very least, women wishing to use oral contraceptives should be strongly urged not to smoke," said Savitri Ramcharan, M.D., of the Contraceptive Drug Study.

To obtain the results, researchers conducted a study on over 16,000 women for more than six years.

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FORMER OSMA PRESIDENT DIES

ARTHUR A. BRINDLEY, M.D., President of the Ohio State Medical Association 1948 to 1949, died on December 24, 1979 in Orlando, Florida, where he lived for the last seven years.

Dr. Brindley was born January 26, 1890 in Swanton, Ohio. He attended college at West Virginia University, Morgantown, West Virginia, and then went to Jefferson Medical College, Philadelphia, where he received his doctor of medicine in 1912. He first practiced in Swanton, Ohio, and in 1913 was president of Fulton County Medical Society. He moved to Port Clinton, Ohio, and was elected president of the Ottawa County Medical Society in 1921. After attending New York Postgraduate School in 1924 he moved to Toledo, and there specialized in anesthesiology. From 1940 to 1960 he served as chief of the department of anesthesiology at St. Vincent Hospital, Toledo. In 1943 he was elected president of the Toledo Academy and Lucas County Medical Society.

Dr. Brindley served during World War I as a First Lieutenant of the U.S. Army Medical Corps.

In 1941 he was elected counselor of the Fourth District of the OSMA, and served through 1947 in this office. He was elected president of OSMA and served 1948 to 1949 in this position.

Dr. Brindley was active in civic affairs of his community and a member of local, state, and national anesthesiologist groups. He is survived by his wife Katherine of 3303 Middlesex Road, Orlando, Florida 32803, one son, Thomas A., and one daughter, Mrs. Val Thomas.

WENDELL H. BENNETT, M.D., Phoenix, Arizona; Case Western Reserve University School of Medicine, 1919; age 88; died January 3; member OSMA and AMA.

ANNE E. CANNON, M.D., Cleveland; New York Medical College, 1936; age 69; died January 4; member OSMA and AMA.

JAMES R. DRIVER, M.D., Sarasota, Florida; Case Western Reserve University School of Medicine, 1916; age 108; died January; member OSMA and AMA.

ELIZABETH M. HIGH (wife of Luther W. High, M.D.), Millersburg; died December 1.

IREDELL M. HINNANT, M.D., Cleveland; South Carolina University School of Medicine, 1930; age 74; died January 8; member OSMA and AMA.

JOHN FREDERICK JOSE, M.D., Damascus; University of Pittsburgh School of Medicine, 1933; age 73; died December 18; member OSMA and AMA.

FREDERICK C. KLUTH, M.D., Painesville; Case Western Reserve University School of Medicine, 1938; age 67; died January 5; member OSMA and AMA.

SALVATOR G. MARINO, M.D., Cleveland; Case Western Reserve University School of Medicine, 1927; age 78; died January 10; member OSMA.

MARION R. MARTIN, M.D., Geneva; Case Western Reserve University School of Medicine, 1930; age 76; died January 13; member OSMA and AMA.

CHARLES W. McGUIRE, M.D., Elyria; Georgetown University School of Medicine, Washington, D.C., 1934; age 74; died January 15; member OSMA and AMA.

CHARLES J. MILLER, M.D., New Philadelphia; Cincinnati Eclectic Medical College, 1918; age 86; died January 2; member OSMA and AMA.

BYRON E. NEISWANDER, M.D., Doylestown; Ohio State University College of Medicine, 1925; age 84; died December 6; member OSMA and AMA.

TIMOTHY F. O'CONNOR, M.D., Ashtabula; St. Louis University School of Medicine, 1930; age 78; died December 14; member OSMA and AMA.

BENJAMIN ROOT, M.D., Cleveland; Case Western Reserve University School of Medicine, 1942; age 61; died December 17; member OSMA and AMA.

ERLE STENTZ ROSS, M.D., Cleveland; Case Western Reserve University School of Medicine, 1920; age 86; died January 14; member OSMA and AMA.

THOMAS P. SHARKEY, M.D., Dayton; University of Cincinnati College of Medicine, 1931; age 75; died December 10; member OSMA and AMA.

FREDERICK SLAUGHTER, M.D., Steubenville; Harvard University School of Medicine; died January 11.

ALVA R. SPINDLER, M.D., Akron; Thomas Jefferson University Medical College, Philadelphia, 1921; age 84; died December 1; member OSMA and AMA.

(continued on page 190)

RUSSELL E. TAYLOR, M.D., Sandusky; Ohio State University College of Medicine, 1934; age 70; died January 11; member OSMA and AMA.

ROSTYSLAW J. WASYLYSHYN, M.D., Toledo; Erlangen University, Erlange, Byaern, Germany, 1947; age 69; died January 15; member OSMA and AMA.

CLIFFORD M. WILCOX, M.D., Cleveland; University of Louisville School of Medicine, 1930; age 74; died December 17; member OSMA and AMA.

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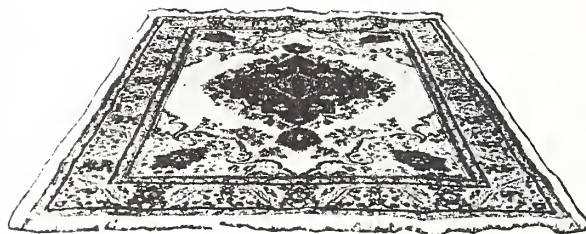
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STATE

Hospital Licensure Bill in Senate Finance Committee

The Senate Finance Committee has before it House Bill 753, the hospital licensure law, which defines a hospital as a medical facility into which patients are admitted by physicians and dentists and which requires that all inpatients be under the medical supervision of a physician. This OSMA-supported language was inserted into the bill in the face of aggressive lobbying by the Ohio Psychological Association to extend hospital admitting privileges to psychologists through state law.

The issue of hospital admitting privileges is of fundamental importance to the continuation of quality health care delivery in Ohio. If psychologists are successful in obtaining admitting privileges by statute, admissions inevitably will be opened to all types of limited practitioners. Physicians must contact their local state senators in person, by telephone, and by mail to thoroughly explain the consequences of an open admissions policy and the necessity of physician supervision of inpatients. For detailed information on this issue please refer to the February and March issues of the Legislative Bulletin.

State Medical Board Revisions Considered

The Senate Education and Health Committee and the House Health and Retirement Committee are hearing three bills designed to reorganize the investigative and enforcement powers of the State Medical Board. Each of the bills (Senate Bill 368 sponsored by Senator Marcus Roberto of Ravenna, HB 1066 sponsored by Rep. Ken Rocco of Parma, and HB 1063 sponsored by Rep. John Thompson of Cleveland) was introduced immediately after a series of *Cleveland Plain Dealer* articles which indicted the board for failure to take effective disciplinary action against mentally incompetent, drug addicted, and unethical practitioners. A summary of the bills is contained in the March issue of the Legislative Bulletin.

The OSMA testified before both committees in support of legislative provisions to increase the effectiveness of the board's policing powers. Specifically, the OSMA supports increased funding and staffing of the board, empowering the board to issue and enforce subpoenas, authorizing the board to take disciplinary action on a temporary basis without a hearing in the event of immediate and extreme emergency, requiring physician counseling of impaired practitioners, and providing for a more swift and effective appeals process.

Both House and Senate committees have established subcommittees to study this issue, on which the sponsors have indicated a desire to work with the OSMA.

Bill Introduced to Prohibit Discrimination Against Medicare Patients

A proposed change to the Medical Practice Act, SB 359, has been introduced to prohibit physician discrimination against Medicare patients. The legislation is sponsored by Senator Charles Butts (D-Cleveland). The bill would prohibit a physician, surgeon, or limited practitioner from (1) asking a patient if he/she is eligible for Medicare benefits, (2) refusing to accept a patient because he/she is eligible for Medicare benefits, or (3) charging a Medicare patient more than the rate determined by the Medicare carrier or the Health Care Financing Administration to be equitable.

SB 359 has been referred to the Senate Commerce and Labor Committee.

Physician Exemption from Gasoline Rationing Passes House

HB 995, which exempts physicians and certain other health care personnel from any potential gasoline rationing system in Ohio, passed the House with little opposition. In his floor speech on the measure Speaker Pro Tempore Barney Quilter (D-Toledo) stressed the necessity of immediate response to medical emergencies as the prime motivation of the bill. The OSMA supports physician exemption legislation on both the State and the Federal level.

Representative Quilter is also the chief sponsor of House Joint Resolution 69, which memorializes Congress to exempt physicians and other specified health care personnel from any Federal gasoline rationing system.

Statutory Definition of Death Proposed

Rep. Don Gilmore (R-Columbus) has introduced a bill, HB 1085, which proposes a definition of death and provides a statutory form by which a person 18 years of age or older may execute a "declaration directing the withholding or withdrawal of life-sustaining procedures" under certain specified circumstances. Physicians who act in accordance with any such "declaration" would be immune from civil or criminal liability.

The bill states:

"A person shall be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition that directly or indirectly caused these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless."

The bill does not provide for a determination of "brain death."

HB 1085 has not been referred to committee. The bill is under review by the OSMA Department of State and Federal Legislation.

Hospice Licensure Bill Introduced

A second piece of legislation concerned with hospices has been introduced into the General Assembly. HB 1103, sponsored by Rep. Robert Taft (R-Cincinnati), requires annual licensure of all hospices in Ohio. The bill directs the Public Health Council to adopt rules governing minimum staffing and service standards for hospices in this state. HB 1103 has yet to be referred to committee.

The Senate Committee on Elections, Financial Institutions, and Insurance is conducting hearings on another hospice bill, SB 360, which requires third-party payers that reimburse for hospital services to pay for hospice services. SB 360 is sponsored by Senator Jerome Stano (D-Parma).

FEDERAL

Truth In Testing

A Federal judge has issued a preliminary injunction against New York State's truth in testing law, which would disclose to the public information about college and graduate admission tests. This is a victory for the Association of American Medical Colleges, which had threatened to cancel the April Medical College Admission Test. This decision apparently only applies to the AAMC, not other scholastic testing organizations. Ohio's HB 636, Zehner (D-Yellow Springs), a bill similar to New York's law and opposed by the OSMA, has not received further hearings.

FTC Rule On Ophthalmic Advertising

The U.S. Court of Appeals for the District of Columbia returned the FTC Ophthalmic Advertising Rule for further hearings and the Court let stand the provision that mandates patients be given copies of their prescriptions. In a 47-page opinion handed down on February 6, on petitions for review brought by AMA, AOA and 14 states, the Court of Appeals concluded, "that the Supreme Court's decision in *Bates v. State Bar of Arizona* . . . has worked changes which, after the rule was promulgated, altered the very nature of the case . . ." The Court left open the **KEY QUESTION** of whether FTC had exceeded its authority to preempt state and local laws, but noted the agency "has at least approached the outer boundaries of its authority and may have infringed" on states' rights.

Privacy Act Clears Committee

By a vote of 26 to 8, the House Government Operations Committee on March 4 approved the Federal Privacy of Medical Information Act, HR 5935. The measure would guarantee patient access to medical information and would limit the disclosure of medical data to third parties. The bill will be referred to at least two other House committees that claim jurisdiction before it can be cleared for floor action. In the Senate there has been no consideration of medical records privacy proposals beyond sporadic hearings.

OSMA OFFICERS	
<i>President</i>	THOMAS W. MORGAN, M.D. P.O. Box 344 Gallipolis 45631
<i>President-Elect</i>	ROBERT G. THOMAS, M.D. 630 East River Street Elyria 44035
<i>Past President</i>	JOHN J. GAUGHAN, M.D. 7911 Detroit Avenue Cleveland 44102
<i>Secretary-Treasurer</i>	DAVID A. BARR, M.D. 825 West Market Street Lima 45805
EDITORIAL STAFF	
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<i>Director, Department of Communications</i>	Rebecca J. Doll
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<i>Regional</i>	The Ohio State Medical Journal 600 South High Street Columbus, Ohio 43215 Telephone: 614/228-6971
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This month's interview features Senator John K. Mahoney, Chairman of the Select Committee to Study Health Care Costs. His committee's findings are discussed with an eye toward medicine's future.

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The OSMA Annual Meeting is to be held this year in Cincinnati, Ohio, May 10 through May 14. A complete listing of schedules, events, programs and other pertinent information can be found in this special Annual Meeting Section.

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To the Editor.— An item in the February 1980 *Journal* notes that the Ohio Department of Public Welfare is falling behind on claim payments again. This is bad enough, but the article also suggests that a substantial part of the problem is due to incorrect completion of claim forms by medical office staffs. That may be true in a narrow sense, but the Department has issued such complex regulations (over 20 pages of *revisions* last month) that only institutions with full-time billing departments can expect to cope with them adequately.

There's a saying in the business world that paperwork you do yourself is loss, while paperwork you pass off on others is profit. The ODPW has not only succeeded in putting a major paperwork burden on physicians, but it now says that any defects in that work are our problem, not theirs. That, on top of delays and arbitrary reductions in claim payments, is adding insult to injury.

/s/ Robert D. Gillette, M.D.

Director

Riverside Family Practice Center
Toledo

To the Editor.— Most of us remember well the malpractice crises of 1975-1976. These days it is heartwarming to realize that in medical circles it is rarely a topic of discussion, though some experts in the field say that, like anything else, malpractice claims also exhibit a cyclic trend. They say that the "claims" peak every five years, and the next one is due in 1980. Other experts congratulate the nationwide physician-owned insurance companies for effectively quelling the surge of malpractice claims and reducing the premium as well.

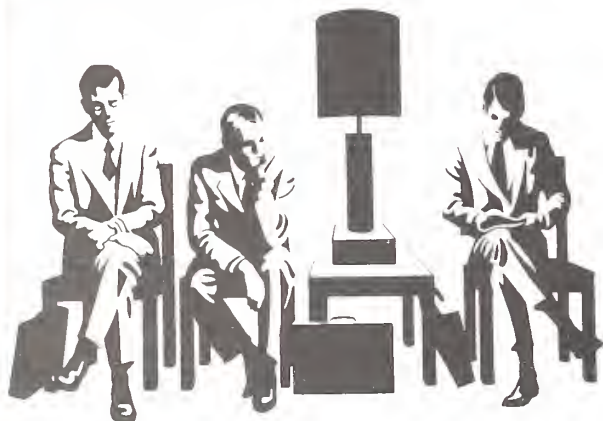
The physician-owned and directed companies obviously have certain advantages in handling the menacing situation. The commercial insurance companies traditionally have handled and settled a claim on the basis of economic considerations alone; however, the physician-run companies, with greater physician input, have been able to use better judgment over the issue of defending a physician. Moreover, being essentially a nonprofit organization, the expenses are kept to a minimum.

All this sounds quite encouraging and reassuring, but the commercial insurance companies that went dormant for the last few years are slowly showing signs of reawakening. Like fair-weather friends, these companies are once again trying to woo the physician community. Their real

(continued on page 200)

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MEDICAL CASES?



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The Challenge of Costs

Cost-containment is not a dead issue in Washington or anywhere else for that matter. Physicians constantly are reminded by government, labor, business, consumer groups and others that the issue of rising medical costs is of paramount importance, and that something should be done about it. The *Challenge* is clear — do it for yourselves or we'll do it for you.

Well, I'm happy to report that Ohio physicians *have* met the *Challenge* and *have* done something about it!

Our commitment to voluntarism and the Ohio Voluntary Effort on Health Care Costs is strong and unyielding. The results of our voluntary efforts to restrain costs played a significant role in the defeat of the Carter administration's mandatory Hospital Controls Bill (HR 2626). The House of Representatives defeated the bill in December and approved a voluntary effort to control hospital costs in the private sector.

Once again physicians in Ohio were requested to restrain increases in fees to at or below the Consumer Price Index levels. The results were resounding. Only twice last year were physicians' services above the "all items" index of the CPI.

The OSMA Committee on Cost-Effectiveness was very active in initiating cost awareness programs. Chiefs of Staffs of all hospitals in Ohio were requested to form a cost-containment committee in their hospitals. The

committee asked medical staff department heads to review all standing orders for cost implications. A new column on Cost-Effectiveness was instituted in the OSMA Journal so that cost-related articles and concepts could be disseminated to the membership. Presidents of all medical specialty societies in Ohio were solicited for articles that deal with costs in their specialty, and specialty section heads were requested to include, where feasible, cost-effectiveness concepts in their presentations at the OSMA Annual Meeting.

The list goes on and on, but clearly shows medicine's commitment to meet the *Challenge* of rising costs.

The key word is *Challenge*. Physicians are accustomed to being challenged from the time they decide to prepare for medical school to the time they look back on a lifetime filled with challenges met and matched. Traditionally, the call has been for excellence — the delivery of quality care under all circumstances and to all patients. I commend you for your response.

We must continue to meet and match the Challenge of cost to insure that quality of care will not be compromised by cost containment efforts. The goal of reducing costs is laudable, but as always, it is the physician who, as the patient's advocate, must meet the Challenge of assuring that quality of care will not suffer in the name of cost containment.

Letters (continued)

interests are obvious—namely, the enormous profits that could come their way.

It is high time we physicians realize that few others have the special interests of the physicians at heart. Hence I suggest that we, as physicians, fight the unfair competition from these commercial companies by reciprocating our support for the physician-owned companies.

/s/**Raman Shanker**
Columbus

To the Editor.—I am a retired physician who takes pride in keeping up with his educational qualifications and license requirements. I well remember when most medical meetings were free, except for the cost of lodging and maybe food. The agencies, hospitals, and physicians who put on the programs, were happy to do so. It provided them with an excellent contact with the medical profession at large, and it was inexpensive advertising.

The compulsory CME has changed all this. Now the physicians at large are compelled to attend these meetings. There are ever-increasing charges which are justified as

being payments for speakers, compensation for the institutions and other program expenses. The CME program works a hardship on some physicians, especially those who practice in rural settings. They must waste time in travel, pay for food and lodging, and pay the ever-increasing fees. This is especially troublesome for retired physicians like myself, and I have addressed various agencies to consider this fact. (The OSMA has agreed to a 20% reduction for retired physicians; and some individual course directors have offered me reduced rates for their particular presentation.)

I suggest that the question of compensation for CME courses to hospitals and to physicians, and the resulting fee schedules for the participants of the courses should be seriously studied, and be put on a more rational basis. (Additional problems may exist with reference to the quality and to the scope of some courses, but this deserves separate discussion by qualified people.)

/s/**Henry Bachman, M.D.**
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AMA Principles Of Medical Ethics —Is It Time To Revise?

BY OSCAR W. CLARKE, M.D.

The AMA has requested that each state review the proposed revision to its Principles of Medical Ethics and make comments to its delegation. My intention is to present both the arguments presented by the Ad Hoc Committee and the primary objections to the revisions. This review is not intended to be a complete presentation of all sides of the issue, but rather should be the basis for discussion of the issue by all members of the OSMA.

While the basis for ethical conduct by physicians has been historical, the written Principles of Medical Ethics have been revised several times. Each revision has attempted to describe better the standards of conduct held by individual physicians pertaining to their relations with colleagues, patients, and society.

The Supreme Court's decisions in *Goldfarb v. Virginia State Bar*, in 1975 and *Bates v. State Bar of Arizona*, in 1977, clearly signaled that professional bodies are to be held accountable for their actions under the antitrust laws.

Since *Goldfarb*, government regulatory and enforcement agencies have instituted proceedings against a number of professional associations, and it was not surprising that the health care industry became one of the principal foci of these efforts.

In 1975, the Supreme Court determined that professionals and professional societies were not exempt from the application of the Sherman Act. In *Goldfarb* the Court noted that:

The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether Section 1 (of the Sherman Act) includes professions.

It has also recently been established that in determining whether an alleged restraint of trade violates the Sherman Act, the inquiry must focus directly on the challenged restraint's impact on competitive conditions. In *National Society of Professional Engineers v. United States*, (1978) the Supreme Court noted that:

The purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring compe-



Oscar W. Clarke is chairman of the Ohio delegation to the AMA.

Revising Ethics (continued)

tion is in the public interest, or in the interest of the members of an industry.

However, in determining whether an alleged restraint violates the antitrust laws, the fact that the restraint arises in the context of a profession is relevant, as the Supreme Court also noted in *Goldfarb*:

The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.

Although the Supreme Court has determined that the antitrust laws do apply to professionals and the activities of their professional association, it also recognized that there are differences inherent in the practice of professions which distinguish professions from the general business context in which the antitrust laws have developed. However, there is substantial uncertainty as to what activities may be undertaken by professional associations which will fall short of unlawful anticompetitive conduct.

During the 1977 Interim Meeting of the American Medical Association House of Delegates, the Judicial Council introduced Report A, "American Medical Association Principles of Medical Ethics," which offered revised principles for consideration. The stated intent of the revision was to clarify and update the language, to reach a proper stance between professional principles and contemporary society and to eliminate any reference to gender. First adopted in 1847, the principles were revised in 1903, 1912, 1947, and 1957.

Special Committee Appointed

Following debate the House deferred action on the revised principles and approved the Judicial Council Report A (A-78) recommending "that a special committee of the House be appointed to consider the revision of the principle further.

This Ad Hoc Committee presented an initial report to the House of Delegates at the 1978 Interim Meeting. In that report the Committee detailed its activities and indicated that while the emphasis of its charge was on the review of the current Principles of Medical Ethics and the revision proposed by the Judicial Council (I-77), the Committee believed that such a review warranted a more comprehensive study of the evolution of ethics in society, the role of ethics for a profession and the consequences of ethical statements in regard to society and law.

In its first report, the Committee submitted the following conclusions to the House:

1. A code of ethics is desirable and necessary to provide guidance during the conduct of a physician's practice.
2. The medical profession is no longer perceived as the sole guardian of the public health, and consequently the traditional paternalism of the profession is in conflict with society.
3. Physicians need to be responsive to their patients, to their profession, to society, and to themselves as individuals without emphasizing one at the expense of the others.
4. The body which generates a code of ethics should be distinct and separate from the body which interprets and enforces that code.
5. A code of ethics should not make reference to gender.
6. Neither the present principles of medical ethics nor the (1977) revised version could be recommended as appropriately articulating the proper ethical stance for the profession.

Although the current principles were considered adequate by some members of the Association, the Committee did not believe its responsibility would be discharged properly without providing the AMA House with a revision which would not only respond to changes in contemporary society, but also would more fully express a physician's dedication to high purposes and ideals.

Preserving Medicine's Position

The Committee's new goal was to develop a version of the Principles of Medical Ethics which, while addressing classical areas of ethical responsibility, also would be contemporary enough to preserve the position of medicine among the professions.

The Ad Hoc Committee concluded that "moral principles are standards of conduct applicable to all segments of society, while ethical principles are standards of conduct in accord with the moral standards of a society, but particularly applicable to a special segment of that society. Medical ethics are, therefore, a specific application of the universal norms of moral behavior. It should not be assumed that there is a special type of ethics appropriate solely to the medical profession. Ethics for a profession depend upon the role of that profession, and, as in medicine, when the role expands, ambiguity and uncertainty appear. Traditionally, ethics evolve from human experience and define what one ought to do. As human experience changes, so does the need for study of ethical behavior."

The arguments for and against the proposed revision focus on several areas. The first is the term in the present preamble "individually and collectively . . . They (the principles) are not laws but standards." As previously stated, the antitrust laws applicable to the collective actions of "competitors" would seem to apply to the pro-

scription of competitive activity included with present principles. The counterassertion is that physicians as a group have a responsibility to society that supersedes current concepts of antitrust law. To provide the highest quality health care, physicians must establish and enforce rules of conduct that often are stricter than prevailing social attitudes.

The proposed revisions also would eliminate the reference "he" when referring to a physician. While few question the technical aspects of the change many believe "he" never was intended to be a gender reference while others contend this proposal is necessary to remove an implicit sexual bias in the principles and to reinforce the AMA policy of physician as a unisex term.

Another proposed revision is the removal of any reference of a prohibition for the solicitation of patients. Some argue that the deletion of a section which states: "He should not solicit patients," is unnecessary because the Judicial Council already has defined "solicitation" so not to include advertising. Others believe that no physician should advertise at all and may attempt to utilize the current language to proscribe legitimate professional advertising.

FTC Ruling Appealed

The AMA continues to appeal the FTC opinion involving the current version of the Principles of Medical Ethics.

The FTC opinion establishes a presumption against professional ethical or conduct rules which are deemed to affect the price of professional services. The decision,

which relies upon the Supreme Court's decision in *Professional Engineers*, indicates that if a professional association imposes a price-affecting restriction on the practices of its members, the restriction may be found unlawful by the FTC regardless of any social value it may serve. (The case challenged the validity of a canon of ethics which prohibited members from submitting competitive bids for their engineering services. A similar opinion was issued challenging the accounting profession.)

The impact of these decisions on any Principles of Ethics is clear, as the FTC held recently in the AMA case:

"Ethical restraints can be justified under the rule of reason . . . only if they promote competition, rather than merely other social goals, and if they are not overly broad."

Some physicians argue that the medical profession is unique and should not have the same standards applied to it as other professions and that the movement by government against professionalism should be fought by medicine. They believe the "principles" are the best place to make this stand, since they are not self-serving but rather serve to protect the public. But other opponents such as Robert M. Sade, M.D., argue:

Medical ethics were not developed for the benefit of society or patients, but rather as guidelines for the physician to behave in a moral manner. It is the physician's honor, integrity, righteousness, honesty, humility, purity, discretion and compassion that are at issue, and his life and art that benefit from their practice. Patients and others benefit from having virtuous, ethical physicians and the FTC has no

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Revising Ethics (continued)

basis to be the propounder of professional ethics.

(Principles of Medical Ethics, A Proposal, p. 37, February Private Practice)

"Voluntary Association" Restriction Challenged

Another controversial change is the removal of the prohibition of voluntarily associating professionally with anyone who does not practice a method of healing focused on a scientific basis. Those who oppose the change argue the revision would leave them at the mercy of any individual who wishes to enhance his or her practice by associating with a licensed physician. The proponents believe that the term "associate with" always has permitted the decision to be made by individual physicians. Whether or not this provision has ever been used by groups of physicians to act collectively is questionable, but the revision allegedly clarifies the issue.

Another group of physicians believes that the present principles have a direct impact on the way the physician organizes his or her practice. They argue that medicine is different from all other commercial and individual enterprises. Organized medicine needs to prohibit economic associations that would limit the physician's freedom to define and determine the best interests of the patient. Only through complete economic freedom will the physician be able to achieve his or her goal of total patient care.

However, many physicians recently have established practice patterns unheard of until a few years ago. Often compensation for services rendered is not based solely upon a particular fee for a particular service. These physicians believe that any interpretation of the Principles of Medical Ethics that could be construed as limiting their economic options while not effecting the quality of patient care should not be permitted.

These are but a few of the arguments for and against the proposed revision of the principles. The *current* and the *proposed* Principles of Medical Ethics are reproduced for your review. Your opinions on this issue should be communicated to the Ohio AMA Delegation prior to the AMA Annual Meeting in July.

Principles of Medical Ethics

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1

The principle objective of the medical profession is to render service to humanity with full respect for the

dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Proposed Principles of Medical Ethics

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of those whom it serves. As a member of this profession, a physician must recognize responsibilities to society, to patients, to other health professionals and to self. The following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1

A physician shall be dedicated to providing medically competent service with compassion and respect for human dignity.

Section 2

A physician shall uphold the honor of the profession by dealing honestly with patients and colleagues and striving to expose those physicians deficient in character, competence, or who engage in fraud or deception.

Section 3

A physician shall respect the law, and also recognize a responsibility to seek changes in those requirements contrary to the best interests of the patient.

Section 4

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law.

Section 5

A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to the public, and utilize the talents of other health professionals when indicated.

Section 6

A physician, except in emergencies, shall be free to choose whom to serve, with whom to associate, and the environment in which to provide services consistent with appropriate patient care.

Section 7

A physician, as a member of society, shall recognize a responsibility to participate in activities contributing to an improved community.

An OSMA Interview

OHIO LOOKS AT CURING

BY REBECCA J. DOLL

EDITOR'S NOTE:

In response to concern over rising health care costs, the leadership of the Ohio Legislature appointed a committee to conduct a statewide study on the problem. The Select Committee to Study Health Care Costs, chaired by Senator John K. Mahoney, D-Springfield, spent the past year traveling around the state conducting numerous interviews with various health professionals in an effort to identify needs and concerns in Ohio. The Committee will issue its final report in early April. The following interview, conducted by Rebecca J. Doll, Director, OSMA Department of Communications, discusses the report and its findings.

OSMA JOURNAL: Senator Mahoney, you and your committee members have spent the past several months traveling the state and interviewing dozens of people regarding health care and health care costs in Ohio. You now have issued a final report which states that there are many inefficiencies in the health care system that are generating tremendous costs without generating benefits. Can you elaborate on what the committee feels are the inefficiencies which are not generating benefits?

SENATOR MAHONEY: Often we get this idea that cost containment means sacrificing quality for cost and it will be the conclusion of the committee that part of our problem has been sacrificing one health care goal for another.

The committee was concerned about several goals, including accessibility, quality, and cost. Historically, cost has not been an area of great concern. It's not been equal to quality and we've never said to ourselves that we want the best quality care for the least number of dollars. So what's happened historically is that sets of incentives and disincentives haven't made cost as important as quality or accessibility. But unless we begin to consider cost, eventually the cost of health care will impact very seriously on accessibility because people will no longer be able to afford the quality care. And that's really the concern of the committee, to provide quality at a reasonable cost to everyone.

JOURNAL: Did the committee identify any specific

inefficiencies in the system which generate costs without generating benefits?

MAHONEY: I think this and other studies have shown that when you have excess beds, excess facilities, excess capacity to spend health care dollars in a hospital setting, that utilization increases. But if you constrict capacity to spend dollars, there are fewer spent, there are fewer admissions, and stays are shorter.

The committee identified several components of the system. Each component, business, labor, government, physicians, consumers, and so forth, played a role from an economic standpoint, and together we acted in a responsible manner for the most part, to create a system which says, "Spend more money." But there has been no incentive for any of the components to ask "Are we spending that money wisely and most efficiently?"

JOURNAL: Will the committee report mention methods by which we can spend the money more efficiently?

MAHONEY: We will say that everyone had a role in creating the situation and everyone will have to have a role in solving it.

For example, we say we have 7,000 excess beds in Ohio. We have a cost control study which says that as occupancy in hospitals goes down, magically the need for special units goes up. All of a sudden everyone needs a burn unit because they have to generate income. Everything in the system says generate revenue. I think the committee will say "Here's an analysis of what's really going on and why it's going on and here are some questions which haven't been asked in the past when we made health care policy," but which must be asked from now on! We're going to have to begin questioning cost more and more. It's a difficult point to get across because we have taken price out of the point of purchase through third-party payment systems. We have an economic system which, as price goes up, demand stays the same or goes down. With health care, as price goes up, demand goes up but that's because we aren't buying health care, we're buying insurance. As health prices go up, we worry about how to pay for it so we go to our insurance carriers and demand more first-dollar coverage and the price skyrockets again.

HEALTH-CARE COSTS

JOURNAL: So you're saying that the basic laws of supply and demand don't work in health care and that's caused problems with costs?

MAHONEY: Right, because these laws are based on price having something to do with the market and in health care that's simply not the case. Maybe we need to take a look at changes in the third-party payment system.

JOURNAL: Did the committee discuss possible changes in the third-party system?

MAHONEY: Yes, we've talked about a couple of approaches but they won't be panaceas. One suggestion was a voucher system on health care packages which would create more alternatives for more people. Our problems aren't really health problems but rather economic problems and we have to develop some strategies to protect the quality and move some of the economic problems out of the way.

JOURNAL: The committee mentioned four strategies—voluntary effort, indirect regulation, direct regulation and the competitive approach. Can you elaborate on the committee's thinking on each of these?

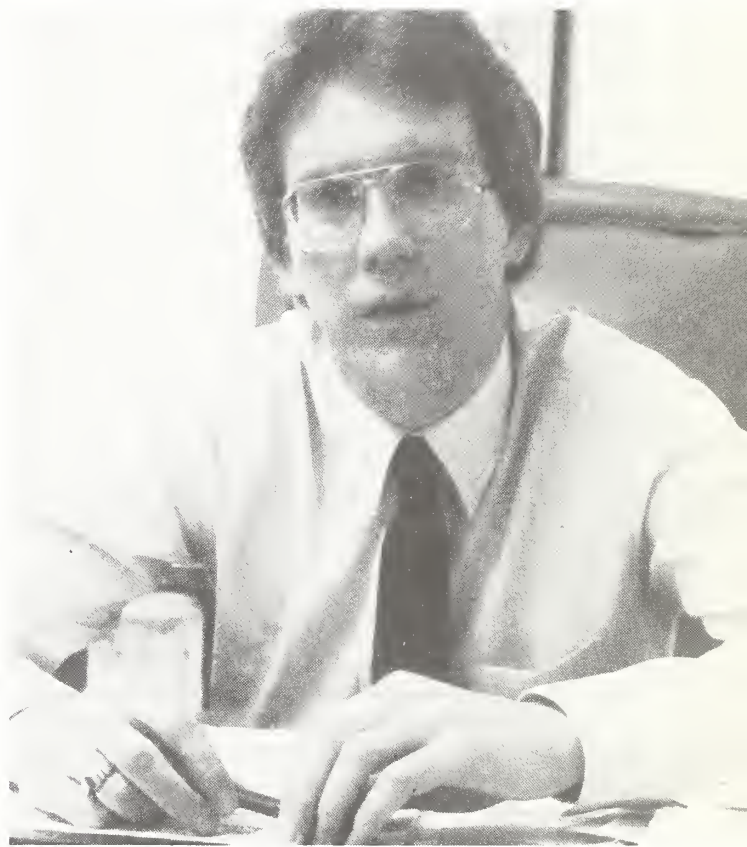
MAHONEY: I think direct regulation is an artificial cap you put on the system and you never really change the incentives and disincentives in the system.

JOURNAL: How about indirect regulation?

MAHONEY: In Ohio, an example of this would be to tell Blue Cross to go out and set limits. That's not reasonable because Blue Cross is only one component in the entire system and it can't, nor should it be able to, control the entire process.

There are two kinds of regulatory systems. One is an incentive style which says "perform better" and the other is a direct regulatory system which says "beat the system." The system is interrelated enough and has enough community support that it could beat any system we develop. There's no law we can write to correct it so I think what you have to do is develop incentives to make it act more efficiently.

JOURNAL: How about the voluntary effort. Can it have a long-term effect or for that matter, has it had any effect?



"With health care, as price goes up, demand goes up, but that's because we aren't buying health care, we're buying insurance."

Curing Costs (continued)

MAHONEY: It's hard to say because the VE ties its performance to the rate of inflation and the increase in health care expenditures. If there is a dampening effect on health care expenditures in relation to inflation, the VE says, "Yes, we did that." But there are lots of other groups within the system saying "No, *we* did that." The HSAs feel they have made an impact with their certificate of need laws. HEW chalks up any decrease to those states having rate-setting commissions and claims those states helped lower the nationwide rate.

Yes, the VE can work in the short run merely by the good intentions of the people involved, but in the long run, I'm not convinced it can.

For example, a hospital in Minnesota got very serious about cost containment. It tried to reduce costs by shortening length of stay and about the time that hospitals got down to 74% occupancy, the board of directors began looking at its books and worrying how it was going to meet its financial obligations. They had bonded indebtedness, a staff to pay, and no money coming in.

JOURNAL: So what we have left is the competitive approach and you're saying that's not what we have now?

MAHONEY: No, and we need to take a look at this approach as a long-term strategy. It won't be easy because we're talking about our style of medical education and our perceptions as providers and consumers totally changing.

JOURNAL: There seems to be an argument as to whether paraprofessionals or allied health practitioners such as physicians' assistants and nurse practitioners, can help lower health care costs. Did the committee discuss this topic or take a position on it?

MAHONEY: I'm not sure the committee will, but I have a personal feeling. Usually, the allied practitioners argue that they can deliver the same quality at lower cost. If we had a competitive health care system, that might be true, but I think what happens in a noncompetitive system such as we have now is that each level of personnel you introduce into the system with more responsibilities, you increase costs. You stack salary schedule upon salary schedule and you introduce an excess capacity to spend health care dollars because many of those practitioners are technicians who require more technology to support their particular practice. All of a sudden you have services that everybody needs, because you have to utilize the services.

Most allied groups probably ought to be discussing the quality of their services rather than arguing they can lower costs because, in a noncompetitive market, this argument won't wash.

JOURNAL: You seem to strongly favor a competitive system. Can you discuss concepts which you feel will introduce competition into the system and how they will be beneficial in the long run?

MAHONEY: I think HMOs (health maintenance organizations) can be beneficial because there are things

in the structure of HMOs that retard their growth so that they won't end up with 90% of a market in a given area. Usually when an HMO pops up, another will also, whether it be an IPA (independent practice association) or whatever. It's a little early in the history of HMOs to say for sure what their impact will be eventually.

JOURNAL: Earlier you said the commission was not out to set blame and that the key is the responsibility each component has in seeing that the system responds to the problems. Did you discuss the roles each must play in controlling costs?

MAHONEY: Yes, and let me just reiterate and say that blame is where someone has done something they shouldn't have done. Responsibility is where you did what you probably should have done and what reason told you to do at the time. The health care system evolved through the responsibilities of each component and there was nothing unreasonable about what people in the system did.

"Our problems aren't really health problems, but rather economic problems."

For example, at the turn of the century we had dozens of medical schools that were shut down and people said the AMA did it to restrict competition. Well, there was good reason those schools were closed down. The quality was terrible and there had to be some quality control developed. Otherwise we would have had a history of butcher medicine.

The hospital association started Blue Cross. Why? Well, if all the hospitals in the country were going under due to the depression, what would you have expected hospitals to do? Government, some people claim, built all these excess beds through the Hill-Burton program. Well, if we didn't have good availability of services throughout the country in a consistent manner, what would you have expected government to do? The point is that each component acted reasonably at the time. Labor and business certainly supported expansion of third-party payment systems.

JOURNAL: To sum up, you seem to feel we have a system of components that developed simultaneously into a single system. But when we've tried to correct the inefficiencies, we have looked at the components separately rather than the system as a whole and that's why we haven't been able to correct many of the problems. Is it reasonable to believe we can look at the system as a whole to make it more efficient?

MAHONEY: Yes, as a society we can be understanding the incentives and disincentives and by resisting the temptation to place blame on one component.



Eric Burkland, OSMA Assistant Director, Department of State and Federal Legislation reviews the Committee's study with Senator Mahoney.

"Our goal is to identify methods of reorganization that will allow an already excellent system of health care become more efficient and not do what many fear it is doing, and that's price itself out of the market."

JOURNAL: Do you feel the components can work together to bring about changes voluntarily or do you believe that this will take government or legislative intervention?

MAHONEY: Not necessarily. If society sets goals and says, "Look, here's where we want to be in ten years," and asks itself, "What should we be doing now voluntarily, to make sure we get there," then government intervention won't be necessary.

But there are things government should be doing and one thing might be the establishment of a redevelopment authority which authorizes communities to determine their own needs and make changes accordingly.

JOURNAL: That's the difficult question. For example, if a community hospital has a cardiac care unit and sees only a handful of patients every year, who makes the decision whether or not that unit is necessary?

MAHONEY: The community. It will have to answer that question.

JOURNAL: Won't most say, "Look, we need that in this community and if you're going to close down some units, close someone else's down, not ours."

MAHONEY: Not necessarily. At least not in a co-operative effort. A redevelopment authority takes some of the financial burden out of the picture. It allows a community for the first time to decide for itself what is and is not needed whether it be a new hospital or a new unit and allows the community to place its finite resources where they will do the most good.

JOURNAL: I question whether a community will do that. Take, for example, what happened two years ago when HEW tried to close down several maternity units in some hospitals around the country. The communities in those areas went wild and subsequently, HEW had to back off in many respects.

MAHONEY: Again, that's an example of price not being visible in the marketplace. There hasn't been a realization in the past of the extra cost of something like that, but I think now there is beginning to be.

JOURNAL: The committee is in the process of writing its final report. You've spent a lot of time and energy getting together what you obviously believe is a good report. Now what? Are we facing legislative action, community involvement? What will you do to insure the report doesn't end up forgotten on a dusty shelf like many reports?

MAHONEY: Well, you won't see a major legislative package coming out of this report. What we'll be saying is that improvements in the system must be systematic, not individual. All components will have to cooperate if we are to succeed in long-term improvement. We hope to place a perspective in the legislature as to what we ought to be doing in regard to health care policy in Ohio. How, for example, do we deal with the dozens of turf issue bills that come along— and that's what many of them are and you have to be willing to recognize them as such— that although they may provide some service and may even improve quality— they won't lower costs. And you have to look at all the options and decide whether or not they'll increase or decrease competition.

JOURNAL: You seem convinced that competition is the answer.

MAHONEY: Of the four strategies, yes, I think it is the one that probably should be encouraged. Our goal is to identify methods of reorganization that will allow an already excellent system of health care become more efficient and not do what many people fear it is doing, and that's price itself out of the market. How we do that will depend upon the various components and their willingness to get together to solve the problems for the common good.

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THE 1980 OSMA ANNUAL MEETING

THE **Ohio** STATE
Medical
Journal

APRIL 1980
Volume 76, Number 4

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STEWART B. DUNSKER, M.D., Cincinnati neurosurgeon, has been nominated for the office of president-elect of the Ohio State Medical Association. His name was placed in nomination by the Academy of Medicine of Cincinnati. Academy President, John E. Albers, M.D., wrote the following letter.

Hart F. Page, Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Hart:

The Academy of Medicine of Cincinnati and the First District Delegation are pleased to nominate Stewart B. Dunsker, M.D., as president-elect of the Ohio State Medical Association.

Dr. Dunsker's peers have repeatedly demonstrated their confidence in his leadership by choosing him to represent them in local, state, and national levels of organized medicine. Dr. Dunsker is Councilor of the First District of the OSMA, and alternate delegate to the AMA. He is also a trustee of the Physicians' Insurance Company of Ohio.

Dr. Dunsker is an innovative, dedicated leader and outstanding spokesman for organized medicine. We nominate him with pride.

Cordially,
/s/ **John E. Albers, M.D.**
President

Candidates For

Stewart B. Dunsker, M.D.

Stewart B. Dunsker, M.D., graduated cum laude from Harvard College in Cambridge, Massachusetts. He then attended the College of Medicine of the University of Cincinnati where, prior to his graduation, he received the Borden Award for undergraduate medical research.

Following a rotating internship at the University of Illinois in Chicago, and an assistant residency in internal medicine at Cincinnati General Hospital, Dr. Dunsker went into active duty as a Captain of the U.S. Army. After his discharge, he returned to Cincinnati General where he served as assistant resident in surgery, then followed as assistant resident, chief resident in neurosurgery at Barnes Hospital in St. Louis, Missouri. He was certified as a Diplomate in the American Board of Neurological Surgery in 1972, and received his Fellowship in the American College of Surgeons a year later.

Dr. Dunsker presently serves as clinician in neurosurgery at the University of Cincinnati, and is active as both the assistant director of the Neurosurgical Resident Training Program and as associate director of the Graduate Training Program at Good Samaritan Hospital in Cincinnati. He also serves as the director of Neurosurgery's Graduate Training Program at Christ Hospital. His past appointments have included a term as adjunct associate professor of anatomy of the University of Cincinnati's Medical Center.

A past secretary of the Cincinnati Academy of Medicine, Dr. Dunsker is currently serving the OSMA as First District Councilor. He also has participated as delegate from the First District on two occasions, and has spent time on many different committees, including his current appointments on the State Legislative Committee, the Task Force on Professional Liability, and the Public Relations Committee.

In addition, Dr. Dunsker chairs the Legal Affairs Committee of the Ohio State Neurosurgical Society and serves on the Board of Directors of PICO.

On the national level, Dr. Dunsker has served as program representative to the neurosurgery section of the American Medical Association and has served as alternate delegate from Ohio to the AMA.

An active member of the Congress of Neurological Surgeons, he has participated and chaired numerous committees, and will serve this year as president of the Society of University Neurosurgeons.

His community activities include service on the Voluntary Health Dollar Study Committee of Community Chest and Regional Advisory Council of the Ohio Valley Regional Medical Program.

President-Elect

J. Hutchison Williams, M.D.

Born in Westerville, Ohio, James Hutchison Williams, M.D., is a graduate of The Ohio State University College of Medicine. He completed his internship at University Hospital in Columbus, Ohio, then completed his residency in obstetrics and gynecology at Mount Carmel Hospital and University Hospital, both in Columbus.

Following his residency, Dr. Williams went on active duty with the U.S. Army as a Captain at the 7071st Army Hospital in Fort Belvoir, Virginia.

A Diplomate of the American Board of Obstetrics and Gynecology, Dr. Williams currently serves as professor of obstetrics and gynecology as well as associate dean of the College of Medicine at Ohio State University.

In addition, Dr. Williams is the attending obstetrician and gynecologist at University Hospital and serves as consulting obstetrician-gynecologist at the Veterans Administrative Center and at Wright-Patterson Air Force Base, both in Dayton, Ohio.

Dr. Williams has been an active member of both the county and state level medical societies for many years. He is a past president and secretary-treasurer of the Academy of Medicine of Columbus and Franklin County, and has served the Academy on numerous committees.

On the state level, Dr. Williams has been a Tenth District Councilor to the Ohio State Medical Association since 1975, serving in the House of Delegates as both delegate and alternate on numerous occasions. He also has been active with many OSMA committees, including his current term as chairman of Auditing and Appropriations Committee.

On a national level, Dr. Williams serves on the Group on Student Affairs for the Association of American Medical Colleges.

In addition to his academic and medical society activities, Dr. Williams serves as president of the Region X Peer Review Systems, Inc., as well as on the Board of Directors of PICO Life Insurance Company, and on the Board of Trustees of the Mid-Ohio Health Planning Federation. He also has served on the Board of Directors of the Franklin County Health Planning Council.

The recipient of numerous honors and awards, including the AOA Honor Medical Society's Alumnus Member Award, Dr. Williams has served the community on various committees, including the Franklin County Health Manpower Committee and the Franklin County Perinatal Health Committee.

Dr. Williams and his wife, Helen, have four children.



J. HUTCHISON WILLIAMS, M.D., Columbus obstetrician-gynecologist, has been nominated for the office of President-Elect of the Ohio State Medical Association. His name was placed in nomination by the Academy of Medicine of Columbus and Franklin County. Academy President, Paul S. Metzger, M.D., wrote the following letter:

Mr. Hart Page
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215
Dear Mr. Page:

By constitutional privilege, the Council of the Academy of Medicine of Columbus and Franklin County unanimously and enthusiastically nominates J. Hutchison Williams, M.D., for the office of President-Elect of the Ohio State Medical Association.

His credentials represent an individual with personal qualifications of the highest possible order. Dr. Williams is eminently qualified for this office by virtue of his distinguished and outstanding contributions to the community, his colleagues and students, the Ohio State Medical Association, and above all, to his patients.

Dr. Williams has shown exceptional leadership as Associate Dean of the Ohio State University College of Medicine, as President of the Academy of Medicine of Columbus and Franklin County, as Tenth District Councilor of the Ohio State Medical Association, and as Chairman of the Auditing and Appropriations Committee of the Ohio State Medical Association.

We are, therefore, proud and pleased to nominate J. Hutchison Williams, M.D., as candidate for the office of President-Elect, knowing that his leadership, knowledge, integrity and skill will enable him to provide outstanding direction to the Ohio State Medical Association.

Respectfully,
/s/Paul S. Metzger, M.D.
President

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Annual Meeting Format

Headquarters Hotel— Stouffer's Cincinnati Towers (SCT)
141 W. Sixth Street

Auxiliary Headquarters Hotel— Terrace Hilton (TH)
15 W. Sixth Street

Cincinnati Convention Center (CCC)
501 Elm Street

Saturday, May 10

Registration

8:00 AM - 1:30 PM, Second Floor Lobby, CCC

Team Building (Physician's Office Supervisor)

8:30 AM - 4:30 PM, Room 203, CCC

12:00 Noon, *Luncheon*, Bamboo A, SCT

You-The Telephone Manager

9:00 AM - 12:00 Noon, Room 213, CCC

Basic Life Support

1:00 - 5:00 PM, Classroom Room 201, CCC

Workstations, Rms. 205 & 207, CCC

Medical Collection Management

(for Medical Office Personnel)

1:00 - 4:00 PM, Room 213, CCC

Managing People & Money (for Physicians)

Section on Family Practice

1:00 - 5:00 PM, Room 211, CCC

Sunday, May 11

Course Registration

7:00 AM - 1:30 PM, Second Floor Lobby, CCC

Advanced Life Support (Continued on Monday)

8:00 AM - 6:00 PM, Classroom Room 201, CCC

Workstations Rms. 205 & 207, CCC

12:00 Noon, *Luncheon*, Bronze Room A, SCT

Media Training Seminar for Physicians

8:30 AM - 3:00 PM, Rms. 214 & 216, CCC

11:45 AM, *Luncheon*, Bronze Room A, SCT

Ohio Delegation to the AMA

2:00 - 4:00 PM, Bamboo Rooms A & B, SCT

House of Delegates

3:00 - 7:00 PM, *Registration*, Grand Ballroom
Foyer, SCT

5:30 PM, *Buffet Dinner*, Bronze Rooms A & B, SCT

7:00 - 9:00 PM, *First Session*, Grand Ballroom, SCT

Councilor District Caucuses

4:00 - 5:30 PM (check suite locations at
registration desk)

Monday, May 12

Reference Committee Registration

7:00 AM, Second Floor Lobby, CCC

Reference Committee Breakfast

7:00 - 8:00 AM, Bronze Rooms A & B, SCT

Reference Committee Hearings

7:30 AM - 2:00 PM

Res. Committee 1— Room 202, CCC

Res. Committee 2— Room 208

Res. Committee 3— Room 214, CCC

President's Address— Cabana A & B, SCT

Nominations, Bamboo A, SCT

Advanced Life Support (Continued from Sunday)

8:00 AM - 5:00 PM, Classroom Rm. 201, CCC

Workstations, Rms. 205 & 207, CCC

12:00 Noon, *Luncheon*, Ivory Room B, SCT



General and Advance Registration

8:30 AM - 5:00 PM, First Floor, CCC

Otolaryngology

8:45 AM - 4:30 PM, Room 203, CCC

12:00 Noon, *Luncheon*, Ivory A, SCT

Dermatology

9:00 AM - 12:00 Noon, Room 216, CCC

Scientific Exhibits

9:00 AM - 4:00 PM, Rms. 210 & 212, CCC

Resource Center

10:00 AM - 2:00 PM, Room 206, CCC

Ohio Health Commissioners

11:00 AM - 4:00 PM, Room 222, CCC

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons ex-
perience a flushing and tingling
sensation after taking a higher
potency nicotinic acid. As a sec-
ondary reaction some will com-
plain of nausea, sweating and ab-

dominal cramps. The reaction is
usually transient.

INDICATIONS: As a cerebral
stimulant and vasodilator.

**RECOMMENDED GERIATRIC
DOSAGE:** One capsule three
times daily adjusted to the indi-
vidual patient.

WARNING: Overdosage may
cause muscle tremor and convul-
sions.

CONTRAINDICATIONS: Epilepsy
or low convulsive threshold.

CAUTION: Federal law prohibits
dispensing without prescription.
Keep out of reach of children.

Write for literature and samples

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Format (continued)

Physical Medicine

12:00 Noon, *Luncheon*, Commodore, SCT
1:00 - 4:00 PM, Room 215, CCC

Rheumatology

12:00 Noon, *Luncheon*, Bamboo B, SCT
1:00 - 5:00 PM, Room 213, CCC

Medicine and Nursing— Can We Work Together

2:00 - 4:00 PM, Room 204, CCC

Ohio State Neurosurgical Business Meeting

4:30 - 6:00 PM, Room 217, CCC

Exhibit Fair

5:00 - 6:30 PM, Grand Ballroom, SCT

Ohio Medical Indemnity Reception

5:00 - 6:30 PM, Ivory A & B, SCT

Tuesday, May 13

Postgraduate Courses

Registration

6:30 AM, Second Floor Lobby, CCC

Electrolytes & Blood Gases

7:30 - 10:30 AM, Room 201, CCC

Scanning-Noninvasive Diagnosis

7:30 - 10:30 AM, Room 203, CCC

OMPAC Board Breakfast

8:00 - 11:00 AM, Ivory A, SCT

Ophthalmology

8:00 - 10:00 AM, *Breakfast*, Bronze Room A, SCT

10:00 AM - 5:00 PM, Room 211, CCC

12:00 Noon, *Luncheon*, Bronze Room A, SCT



Ohio Psychiatric Association Board

8:00 - 11:30 AM, Room 217, CCC

11:30 AM, *Luncheon*, Bamboo Rooms A & B, SCT

Ohio Psychiatric Association

1:00 - 5:00 PM, Room 217, CCC

General and Advance Registration

8:30 AM - 5:00 PM, First Floor, CCC

Ohio Health Commissioners

9:00 AM - 4:00 PM, Room 222, CCC

Pathology

9:00 AM - 4:30 PM, Rooms 205 & 207, CCC
12:30 PM, *Luncheon*, Bronze Room B, SCT

Scientific Exhibits

9:00 AM - 4:00 PM, Rooms 210 & 212, CCC

Ohio Chapter, American Academy of Pediatrics, Executive Committee

9:00 AM - 12:15 PM, Room 213, CCC
12:15 PM, *Luncheon*, Commodore, SCT



Neurosurgery

9:00 AM - 5:00 PM, Room 204, CCC
12:00 Noon, *Luncheon*, Ivory A, SCT

Internal Medicine

9:00 AM - 12:00 Noon, Room 208, CCC

Pfizer Dialogue

9:00 AM - 4:00 PM, Room 202, CCC

Resource Center

10:00 AM - 2:00 PM, Room 206, CCC

OMPAC Luncheon

11:30 AM - 2:00 PM, Grand Ballrooms A & B, SCT

Sports Medicine Luncheon

12:00 Noon, Ivory B, SCT

Ohio Chapter, American College of Emergency Physicians

1:30 - 4:30 PM, Room 214, CCC

Medical Mutual Reception

5:00 - 6:30 PM, Ivory A & B, SCT

OSMA Social Function

6:30 PM, Queen City Club

Wednesday, May 14

Postgraduate Courses Registration

6:30 AM, Second Floor Lobby, CCC

Computers in Your Practice

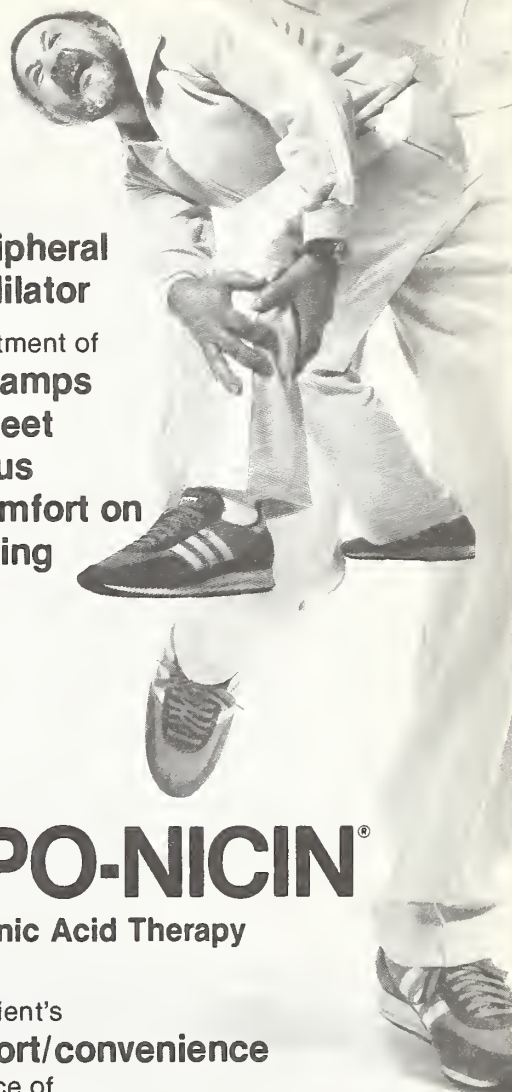
7:30 - 10:30 AM, Room 201, CCC

Drug Therapeutics

7:30 - 10:30 AM, Room 203, CCC

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
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in choice of
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LIPO-NICIN®/300 mg.

Each time-release capsule contains:

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Thiamine HCL (B-1) 25 mg.
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in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
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Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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2500 West Sixth Street, Los Angeles, California 90057



Format (continued)

ENT Update

7:30 - 10:30 AM, Room 205, CCC

General and Advance Registration

8:30 AM - 5:00 PM, First Floor, CCC

Allergy

8:30 AM - 12:00 Noon, Room 213, CCC

Ohio Committee on Trauma

9:00 AM - 12:00 Noon, Room 214, CCC

Scientific Exhibits

9:00 AM - 4:00 PM, Rooms 210 & 212, CCC

Ohio Health Commissioners

9:00 AM - 4:00 PM, Room 222, CCC

Plastic Surgery

9:00 AM - 12:00 Noon, Room 202, CCC

12:15 PM, *Luncheon*, Bronze A, SCT

Resource Center

10:00 AM - 2:00 PM, Room 206, CCC

OSMA Committee on Scientific Work

12:00 Noon, *Luncheon/Meeting*, Ivory B, SCT

Anesthesiologists

1:30 - 4:30 PM, Room 207, CCC

House of Delegates

2:30 - 3:30 PM, Registration, Grand Ballroom
Foyer, SCT

3:30 - 10:00 PM, *Final Session*, Grand Ballroom
A & B, SCT

6:00 PM, *Buffet Dinner*, Bronze Rooms A & B, SCT



Thursday, May 15

Council Meeting Breakfast

8:30 - 10:00 AM, Grand Ballroom A, SCT

PICO Stockholders Meeting

10:00 AM, Bronze A, SCT

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Meeting Room Locations

In Stouffer's Cincinnati Towers

Second Floor - Ballroom Level

Grand Ballroom A
Grand Ballroom B
Foyer
Bronze Ballroom A
Bronze Ballroom B
Bamboo A
Bamboo B
Ivory A
Ivory B

First Floor

Commodore

In Cincinnati Convention Center

Second Floor - North

Room 200
Room 202
Room 204
Room 206
Room 208
Room 210
Room 212
Room 214
Room 216
Room 218
Room 220
Room 222

Second Floor - South

Room 201
Room 203
Room 205
Room 207
Room 209
Room 211
Room 213
Room 215
Room 217
Room 219
Room 221
Room 223
Room 225
Room 227
Room 229

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, non-medical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on ad-

ministrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

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There are plenty of other great benefits that go with being a Navy physician. Good pay—\$30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

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Continuing Medical Education Courses

Postgraduate Courses

Use form on page 258 to register.

(Asterisks indicate fee courses.)

ADVANCED LIFE SUPPORT (CPR) (Two-day Course)

CME Hours: 14 Category I
Fee: \$140*
Date: Sunday, May 11, and Monday, May 12
Place: Room 201, Cincinnati Convention Center
Time: 8 AM - 6 PM Sunday and Monday
Sponsor: OSMA Committee on Scientific Work in cooperation with Ohio Heart Association

Course Director: *William H. Gates, M.D.*, Cincinnati, Chairman, State of Ohio Emergency Medical Services Advisory Council, and Chairman, OSMA Committee on Emergency and Disaster Medical Care

Course Description: Certification in Basic Life Support a prerequisite. In cooperation with Southwestern Ohio Heart Association, Advanced Life Support Course provides instruction in the following: use of adjunctive equipment, arrhythmia recognition and cardiac monitoring, defibrillation and cardioversion, establishing and maintaining intravenous fluid lifelines, drug therapy to correct acidosis shock and serious arrhythmias, and stabilization of patient's condition for transportation. Registrants will be certified according to standards of American Heart Association.

BASIC LIFE SUPPORT (CPR)

CME Hours: 5 Category I
Fee: \$50*
Date: Saturday, May 10
Place: Room 201, Cincinnati Convention Center
Time: 1 - 6 PM Saturday
Sponsor: OSMA Committee on Scientific Work in cooperation with Ohio Heart Association

Course Director: *William H. Gates, M.D.*, Cincinnati, Chairman, State of Ohio Emergency Medical Services Advisory Council, and Chairman, OSMA Committee on Emergency and Disaster Medical Care

Course Description: A prerequisite for Advance Cardiac Life Support Course. In cooperation with Southwestern Ohio Heart Association, course will cover early warning signs and signals for survival from sudden respiratory and cardiac arrest. Also practical skills in management of one- or two-person CPR, infant resuscitation, relief of obstructed airway, and

witnessed cardiac arrest will be covered. A medical care system will be discussed. Certification in Basic Life Support is goal of this course.

COMPUTERS IN YOUR MEDICAL PRACTICE

CME Hours: 3 Category I
Fee: \$30*
Date: Wednesday, May 14
Place: Room 201, Cincinnati Convention Center
Time: 7:30 - 10:30 AM
Sponsor: OSMA Committee on Scientific Work

Course Director: *Frederick V. Light, M.D.*, Assistant Clinical Professor of Family Medicine, Case Western Reserve University School of Medicine

Additional Faculty: *Robert L. Jewell*, President, Medical Economics, Dayton

Course Description: This course will not teach computer programming or computer technology in any way. It is designed only to provide a better understanding of what computers can do, what medical office needs are, and how computers can answer these needs in a practical and easily financed way. After attending the course, physicians will be able to evaluate the computer services which are offered by commercial organizations and to match them against specific needs; to be familiar with the way a computer can be used for medical records and computer billing; and to be familiar with the differences between on-line, mini-computer, and batch processing.

DERMATOLOGY FOR NONDERMATOLOGISTS

CME Hours: 3 Category I
Fee: \$30*
Date: Monday, May 12
Place: Room 216, Cincinnati Convention Center
Time: 9 AM - 12 Noon

Course Director: *James M. Marrs, M.D.*, Clinical Assistant Professor Dermatology, University of Cincinnati Medical Center

Additional Faculty: *Lee Vesper, M.D.*, Clinical Assistant Professor Dermatology, University of Cincinnati Medical Center
Thomas G. Kreindler, M.D., Clinical Instructor, Dermatology, University of Cincinnati Medical Center

Schedule:

Diagnostic Principles— *James M. Marrs, M.D.*

CME Courses (continued)

- Introduction
- Principles of Dermatologic Diagnosis
- Patterns of skin disease
 - Papulosquamous differential— Psoriasis, pityriasis rosea, syphilis, Tinea versicolor, Tinea, eczema, drug, etc.
 - Urticarial patterns— urticaria, E. multiforme, annular eruption
 - Vesiculo bullous diseases— pemphigoid, pemphigus, dermatitis, herpetiformis.
- Skin tumors— Lee J. Vesper, M.D.
- Basal cell carcinoma, squamous cell carcinoma
- Bowen's and Paget's disease
- Pigmented lesions
 - Nevi— when and what to biopsy
 - Diagnosis and treatment of malignant melanomas
- 10:30 - 10:45 Break
- Common Cutaneous Infections— Thomas G. Kreindler, M.D.
- Bacterial Infections— Impetigo, Cellulitis, Erysipelas
 - Staphylococcal Infections
- Viral Infections— Herpes simplex, Herpes zoster
- Warts
- Molluscum contagiosum
- Fungal and yeast infections— Dermatophytes
- Candidiasis
- Infestations— Scabies, pediculosis
- 11:30 - 12 Noon Questions and Answers, Discussion

*“A week
to remember”*

**OHIO STATE
MEDICAL
ASSOCIATION**

**Annual Meeting
May 10-14**

ELECTROLYTES AND BLOOD GASES

CME Hours: 3 Category I
Fee: \$30*
Date: Tuesday, May 13
Place: Room 201, Cincinnati Convention Center
Time: 7:30 - 10:30 AM
Sponsor: OSMA Committee on Scientific Work

Course Director: *Michael C. Laver, M.D.*, Assistant Clinical Professor, Division of Nephrology, Department of Internal Medicine, University of Cincinnati College of Medicine

Course Description: The course is designed to elucidate the mechanisms of common electrolyte and acid base disturbances and help facilitate the management. Common and difficult problems will be analyzed.

ENT (OTOLARYNGOLOGY) UPDATE — 1980

CME Hours: 3 Category I
Fee: \$30*
Date: Wednesday, May 14
Place: Room 205, Cincinnati Convention Center
Time: 7:30 - 10:30 AM
Sponsor: OSMA Committee on Scientific Work

Course Director: *S. George Lesinski, M.D.*, Director, Division of Otolaryngology and Neuro-Otolaryngology, University of Cincinnati Medical Center, Cincinnati

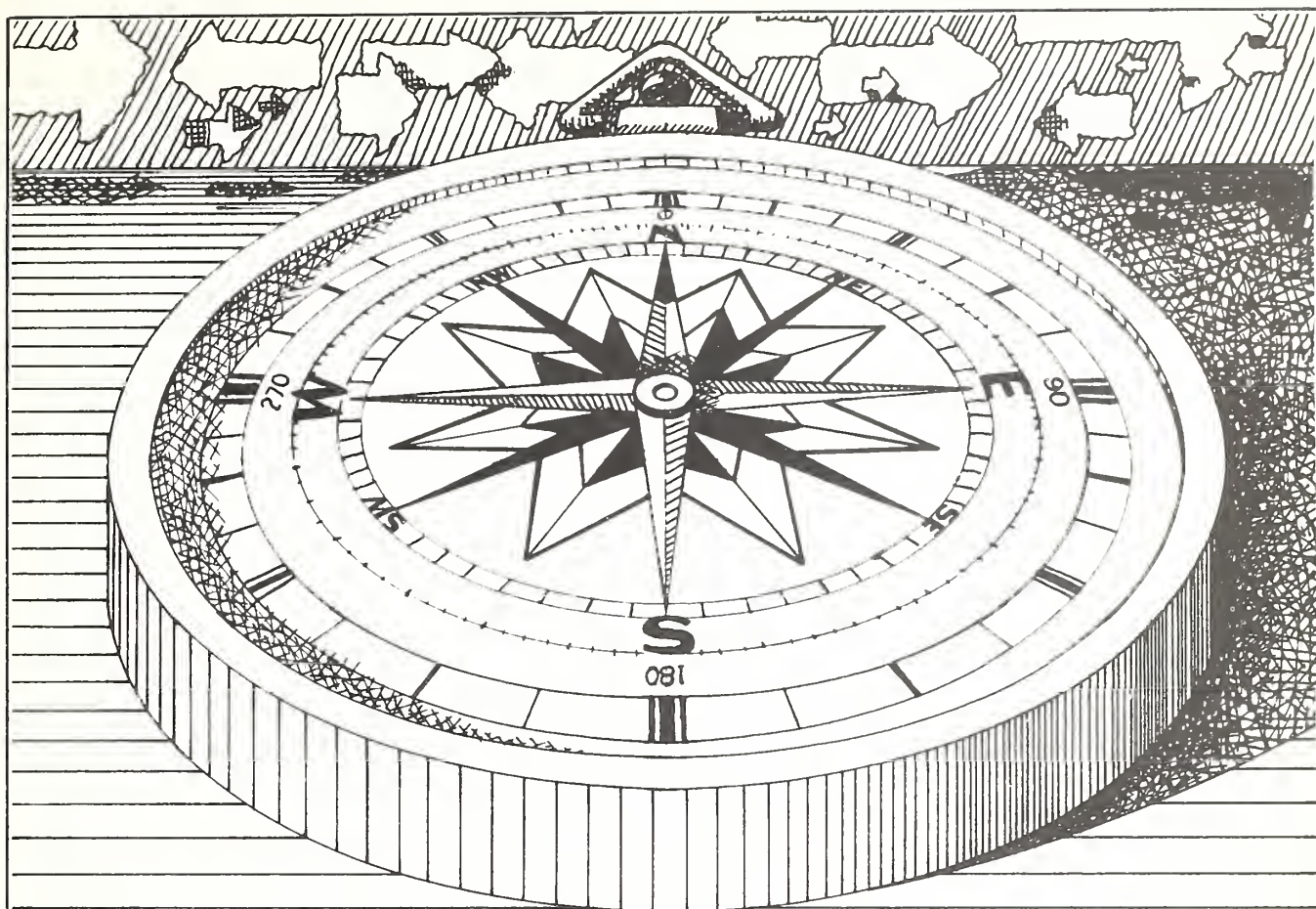
Additional Faculty: *Robin Cotton, M.D.*, and *Jack Gluckman, M.D.*, Division of Otolaryngology and Neuro-Otolaryngology, University of Cincinnati Medical Center, Cincinnati

Course Description: The following three categories will be covered in the Otolaryngology Update-1980: Recent Advances in the Past Decade of Diagnostic and Therapeutic Techniques in Pediatric Otolaryngology; Otolaryngology Update-1980; and Advances in Head and Neck Surgery.

MANAGING PEOPLE AND MONEY IN YOUR PRACTICE

CME Hours: 4 Category 1; or 4 Prescribed Hours, AAFP
Fee: \$40*
Date: Saturday, May 10
Place: Room 211, Cincinnati Convention Center
Time: 1-5 PM
Sponsor: OSMA Section on Family Practice in cooperation with the AMA Department of Practice Management

Course Description: This workshop is designed for physicians in both solo and group practices. The course focuses on improved personnel and financial management. Specifically, the workshop will discuss: personnel policy manuals, employee motivation, med-



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Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

CME Courses (continued)

ical accounts receivable management, and cost containment. Each participant will receive a manual which supplements the lecture and provides forms for implementation of policies which will be covered.

MEDIA TRAINING SEMINAR FOR PHYSICIANS

CME Hours: 6 Category I
Fee: \$60*
Date: Sunday, May 11
Place: Rooms 214 & 216, Cincinnati Convention Center
Time: 8:30 AM - 3 PM
Sponsor: OSMA Department of Communications in cooperation with the Committee on Scientific Work

Course Description: The seminar will be conducted by Mortimer Enright of the American Medical Association and the OSMA Department of Communications. You will learn the techniques of working with the media and have an opportunity to participate in mock news conferences, interviews, and talk shows. This seminar is especially suited to physicians who are elected spokespeople for their county medical society. Take advantage of this opportunity to learn how to tell medicine's story more effectively, learn how to deal with the media and get your story told by attending the OSMA Media Training Seminar.

TEAM BUILDING OFFICE MANAGER

Fee: \$60*
Date: Saturday, May 10
Place: Room 203, Cincinnati Convention Center
Time: 8:30 AM - 4:30 PM
Sponsor: OSMA Committee on Scientific Work

Course Director and Faculty: Practice Management Department, American Medical Association

Course Description: For the physician's office supervisor. Improving the physician's right hand—the office supervisor—is the objective of this day-long intensive workshop. Office supervisory personnel will sharpen the skills they need to develop to manage the medical team. They will learn how to recruit, interview, and hire employees; develop meaningful job descriptions and personnel policies; train and motivate employees to be "key players." Role playing, case studies, and discussion make this workshop a "must."

YOU, THE TELEPHONE MANAGER

Fee: \$30*
Date: Saturday, May 10
Place: Room 213, Cincinnati Convention Center
Time: 9 AM - 12 Noon
Sponsor: OSMA Committee on Scientific Work

Course Director and Faculty: Practice Management Department, American Medical Association

Course Description: For medical office personnel. Medical office personnel will learn how to communicate better and to improve patient relations. Designed to sharpen medical assistant's interpersonal communication skills—particularly those used daily in the office. Learn proven techniques on writing a patient-information booklet, telephone management time savers, new medical office management approaches, and ways to avoid medical-legal conflicts.

DRUG THERAPEUTICS

CME Hours: 3 Category I
Fee: \$30*
Date: Wednesday, May 14
Place: Room 203, Cincinnati Convention Center
Time: 7:30 - 10:30 AM
Sponsor: OSMA Committee on Scientific Work

Course Director: Kazuo K. Kimura, M.D., Ph.D., Director, Group in Clinical Pharmacology, Wright State University School of Medicine

Course Description: An active learning program designed for the busy practitioner of medicine. Mechanism-oriented therapeutic rationale will be discussed including prevention of adverse reaction, interaction and toxicity.

SCANNING-NONINVASIVE DIAGNOSIS

CME Hours: 3 Category I
Fee: \$30*
Date: Tuesday, May 13
Place: Room 203, Cincinnati Convention Center
Time: 7:30 - 10:30 AM
Sponsor: OSMA Committee on Scientific Work

Course Director: Atis Fremanis, M.D., Columbus

MEDICAL COLLECTION MANAGEMENT

Fee: \$30*
Date: Saturday, May 10
Place: Room 213, Cincinnati Convention Center
Time: 1 - 4 PM
Sponsor: OSMA Committee on Scientific Work

Course Director and Faculty: Practice Management Department, American Medical Association

Course Description: This course's objective is to increase effectiveness of medical assistants in handling the office collection program. It will cover how to set up collection policies and a timetable; how to write result-producing collection letters; how to call patients about overdue accounts and improve patient compliance; developing an insurance follow-up sys-

tem; and keeping the legal and ethical considerations of the collections process in perspective.

Specialty Section Programs

ALLERGY AND IMMUNOLOGY

Topic: Allergic Emergencies— Diagnosis and Management
CME Hours: 4 Category I
Date: Wednesday, May 14
Place: Room 213, Cincinnati Convention Center
Time: 8:30 AM - Noon
Sponsor: OSMA Section on Allergy and Immunology and Ohio Society of Allergy and Immunology

Course Director: *Thomas J. Fischer, M.D.*, Assistant Professor of Pediatrics Director, Division of Allergy/Immunology, Children's Hospital Medical Center, Cincinnati

Schedule:

8:30 AM *Anaphylaxis*— I. Leonard Bernstein, M.D., Director of Allergy, Division of Immunology, Department of Medicine, University of Cincinnati Medical Center, Cincinnati

9:30 AM *Status Asthmaticus*— James Kennealy, M.D., Assistant Professor of Medicine, Department of Internal Medicine, University of Cincinnati Medical Center

10:30 AM Break

10:45 AM *Hymenoptera Sensitivity*— Diagnosis and Management— John W. Yunginger, M.D., Allergic Disease Research Laboratory, Mayo Clinic, Rochester, Minnesota

11:45 AM *Panel Discussion*— Drs. Bernstein, Kennealy and Yunginger. Thomas J. Fischer, M.D., Moderator

12:30 PM *Luncheon*— Mike Fink's Restaurant

ANESTHESIOLOGY

Topic: Evaluation and Management of Three Difficult Anesthetic Problems— 1980
CME Hours: 3 Category I
Date: Wednesday, May 14
Place: Room 207, Cincinnati Convention Center
Time: 1:30 - 4:30 PM
Sponsor: OSMA Section on Anesthesiology and Ohio Society of Anesthesiologists

Course Director: *Richard E. Park, M.D.*, Assistant Professor of Anesthesia, University of Cincinnati Medical Center, Cincinnati

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\$2 Carmine & Black
1920 SC No.547 Mint

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June, 1979 - \$352

Feb., 1980 - \$935



£1 Yellow & Dark Violet
1933 SC No.165 Mint

Auction Price:

June, 1979 - \$1,375

Feb., 1980 - \$2,970



15/ Violet & Black on Blue
1922 SC No.94 Mint

Auction Price:

June, 1979 - \$935

Feb., 1980 - \$4,600

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CME Courses (continued)

Presiding Officer: *Thomas H. Joyce III, M.D.*, Professor of Anesthesia; Associate Professor of Ob-Gyn, University of Cincinnati Medical Center, Cincinnati

Schedule:

- 1:40 PM *Evaluation and Anesthetic Management of the Pulmonary Cripple*— Brian Tobias, M.D., Assistant Professor of Anesthesia, University of Cincinnati Medical Center, Cincinnati
- 2:30 PM *Evaluation and Anesthetic Management of the Morbidly Obese*— Norman H. Blass, M.D., Associate Professor of Anesthesia and Ob-Gyn, Wright State University School of Medicine, Dayton
- 3:15 PM Break
- 3:45 PM *Anesthetic Approach to the Physiology of Pregnancy*— Thomas H. Joyce III, M.D., Professor of Anesthesia, Associate Professor of Ob-Gyn, University of Cincinnati Medical Center, Cincinnati

EMERGENCY PHYSICIANS

Topic: The Historical and Financial Aspects of Free-Standing Emergency Centers

CME Hours: 3 Category II

Date: Tuesday, May 13

Place: Room 214, Cincinnati Convention Center

Time: 1:30 - 4:30 PM

Sponsor: Ohio Chapter, American College of Emergency Physicians

Presiding Officer: *Clyde Watson, M.D.*, Program Chairman, Ohio Chapter, American College of Emergency Physicians, Centerville

Guest Speaker: *Mr. Craig Bivens*, Dallas, Texas

Program Description: The following aspects of Free-Standing Emergency Centers will be covered by Mr. Bivens: 1) History and Concept. The development of concepts as to the present and future. 2) Market Research. The necessary ingredients for a successful location. 3) Legal Structure and Financial Planning. Different alternatives available for ownership in financing a free-standing center. 4) Design and Construction. 5) Certificate of Need. 6) Public Relations and Marketing Alternatives to Create Public Awareness. 7) Financial Requirements. Projections and operational cost requirements. 8) Economic Results. Financial projections and profitability requirements for Free-Standing Emergency Centers.

INTERNAL MEDICINE

CME Hours: 3 Category I

Date: Tuesday, May 13

Place: Room 208, Cincinnati Convention Center

Time: 9 AM - 12 Noon

Sponsor: OSMA Section on Internal Medicine and the Ohio Society of Internal Medicine

Schedule:

- 9:00 AM *Non-Hodgkin's Lymphoma (Treat to Cure; When Not to Treat)*— Carl Siegrist, M.D., Cincinnati and A. William Schreiner, M.D., Director, Department of Internal Medicine, Christ Hospital, Cincinnati
- 10:00 AM *Oncologic Emergencies*— David L. Kirlin, M.D., Cincinnati
- 11:00 AM *Neoplasms of Reproductive Organs in Women*— Richard Meyer, M.D., Cincinnati

MEDICINE AND NURSING

Topic: Medicine and Nursing— Can We Work Together?

CME Hours: 2 Category II

Date: Monday, May 12

Place: Room 204, Cincinnati Convention Center

Time: 2 - 4 PM

Sponsor: OSMA Committee on Health Manpower (Liaison Subcommittee with the Ohio Nurses Association) and Ohio Nurses Association

Course Director: *William M. Wells, M.D.*, Newark, Chairman, Liaison Subcommittee with the Ohio Nurses Association, Committee on Health Manpower

Schedule:

- 2:00 PM *Welcome and Introductions*— William M. Wells, M.D.
- 2:10 PM *An Overview-Nursing from the Physician's Viewpoint*— Thomas W. Morgan, M.D., Gallipolis, President, Ohio State Medical Association
- 2:30 PM *An Overview— Medical Practice from the Nurses' Viewpoint*— Gertrude Torres, R.N., Ed.D., Dayton, President, Ohio Nurses Association
- 3:50 PM **Reactor Panel**
Two representatives from ONA (10 minutes each)
Two representatives from OSMA (10 min. each)
- 3:30 PM *Questions and Answers* (audience participation)
- 4:00 PM Adjourn

NEUROSURGERY

Topic: Infections of Neurosurgical Import

CME Hours: 6 Category I

Date: Tuesday, May 13

Place: Room 204, Cincinnati Convention Center

Time: 9 AM - 5 PM
Sponsor: OSMA Section on Neurosurgery and
Ohio State Neurosurgical Society

Course Director: Jerald S. Brodkey, M.D., Program
Chairman, Case Western Reserve University, Uni-
versity Hospitals, Cleveland

Schedule:

- 9:00 AM *Current Guidelines for Diagnosis and Sys-
temic Therapy of CNS Infections*— Earl H. Frei-
mer, M.D., Professor of Medicine, Director, Divi-
sion of Infectious Disease, Medical College of Ohio
at Toledo
- 9:40 AM *Intracranial Suppuration*— Shelley N.
Chou, M.D., Professor and Director of Neurosur-
gery, University of Minnesota, Minneapolis, Minn.
- 10:20 AM Break
- 10:40 AM *Prophylactic Antibiotics in Neurosurgery,
Pros and Cons*— Arthur I. Kobrine, M.D., Assis-
tant Professor of Neurosurgery, George Washing-
ton University, Washington, D.C.
- 11:20 AM *Shunt Infections*— Robert McLaurin, M.D.,
Chief of Neurosurgery, University of Cincinnati
- 12 NOON *Luncheon*— Ivory A. Stouffer's Cincinnati
Towers

OPEN PROGRAM

- 2:00 PM *Current Status of Neurosurgical Interven-
tions for Control of Drug Refractory Epilepsy*—
Mark Rayport, M.D.
- 2:30 PM *Management of Large Schwannomas of the
Jugular Foramen and Base of the Skull*— Bhupin-
der Sawhny, M.D., Russell W. Hardy, Jr., M.D.,
Sam E. Kinney, M.D., Joseph F. Hahn, M.D.,
Donald F. Dohn, M.D., Harvey M. Tucker, M.D.
- 2:45 PM *Clinical Studies of Trigeminal Neuralgia—
Is There a Simple Cause?*— John M. Tew, Jr.,
M.D., Jeffrey T. Keller, Ph.D., Edmund Frank,
M.D., Mary Ann Nurre, R.N., Robert Lukin,
M.D., Boleslaw Liwnitz, M.D.
- 3:00 PM *Infectious Complications of Percutaneous
Procedures for the Treatment of Trigeminal Neu-
ralgia*— James M. Vascik, M.D., John M. Tew,
Jr., M.D., Rafael Ramirez, M.D.
- 3:15 PM *Recurrent Shunt Failure Due to Congenital
or Acquired Intraventricular Membranes*— Arthur
M. Gerber, M.D., Edward R. Savolaine, M.D.,
James H. Harris, Ph.D., M.D., Frank Redmond,
B.S.
- 3:30 PM *Clinical Trials of Glycerol for the Treatment
of Intracranial Hypertension*— Steven L. Wald,
M.D., Robert L. McLaurin, M.D., and James E.
McLennan, M.D.

3:45 PM Break

- 4:00 PM *The Congenitally Narrow Cervical Spinal
Canal: Some Unsolved Problems*— Carole A. Mil-
ler, M.D., William E. Hunt, M.D.
- 4:15 PM *Vasculitis Involving the Extracranial Cere-
bral Circulation*— Edmund Frank, M.D., John M.
Tew, Jr., M.D.
- 4:30 PM *DE NOVO Intracranial Aneurysms*— Ste-
phen A. Hill, M.D., Carole A. Miller, M.D., Wil-
liam E. Hunt, M.D.
- 4:45 PM *Barbiturate Control of Ischemic Edema:
Comparison of Effect on Permanent and Tempo-
rary Middle Cerebral Artery Occlusion in Baboons*
— Warren R. Selman, M.D., Robert F. Spetzler,
M.D.
- 5:00 PM *Extracranial-Intracranial Bypass Procedures
in the Carotid System*— Ghahreman Khodadad,
M.D.
- 5:15 PM *Cerebral Blood Flow in Superficial Tem-
poral Artery to Middle Cerebral Artery Anasto-
mosis*— John R. Little, M.D.

PEDIATRICS

Date: Tuesday, May 13
Place: Room 213, Cincinnati Convention Center

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CME Courses (continued)

Time: 9 AM - 12 Noon
Sponsor: Ohio Chapter, American Academy of Pediatrics

Program Director: Leonard P. Rome, M.D., Cleveland, Chairman, Ohio Chapter, American Academy of Pediatrics

Program Description: Executive Committee Session of the Ohio Chapter, American Academy of Pediatrics. Business Meeting and open program on Accident Prevention

Schedule:

12:15 PM *Luncheon*— Commodore Room, Stouffer's Cincinnati Towers

OPHTHALMOLOGY

Topic: The Diabetic Eye
CME Hours: 3 Category I
Date: Tuesday, May 13
Place: Room 211, Cincinnati Convention Center
Time: 1:30 - 5 PM
Sponsor: OSMA Section on Ophthalmology and Ohio Ophthalmological Society

Course Director: Sterling J. Haidt, M.D., Cincinnati Retinal Associates; Clinical Instructor of Ophthalmology, University of Cincinnati College of Medicine

Schedule:

- 1:30 PM *Introduction— Overview*— Dr. Haidt
- 1:30 PM *Diabetologist's View of the Eye in Diabetes*— Kenneth Kreines, M.D., Professor of Medicine (Clinical), Department of Medicine, University of Cincinnati School of Medicine
- 1:45 PM *Pathology of the Diabetic Eye*— Abbot G. Spaulding, M.D., Professor of Ophthalmology, University of Cincinnati School of Medicine
- 2:05 PM *Orbital Mucormycosis in the Diabetic Patient*— John D. Bullock, M.D., Assistant Clinical Professor of Ophthalmology, Wright State University School of Medicine, Dayton
- 2:15 PM *Anterior Segment Problems in the Diabetic Patient*— Richard Keates, M.D., Professor of Ophthalmology, Ohio State University School of Medicine
- 2:25 PM *Glaucoma in a Diabetic Patient*— John S. Cohen, M.D., Assistant Professor of Ophthalmology (Clinical), University of Cincinnati School of Medicine
- 2:40 PM *Neuro-ophthalmological Complications in Diabetes*— William E. Cappaert, M.D., Assistant Professor of Ophthalmology, Case Western Re-

serve University School of Medicine

2:55 PM *Ultrasonography in the Preoperative Evaluation of a Diabetic*— Carol B. Kollarits, M.D., Chairman, Division of Ophthalmology, Medical College of Ohio at Toledo

3:05 PM Break

3:35 PM *Vitreous Surgery in the Diabetic*— Allan E. Kreiger, M.D., Professor of Ophthalmology, Jules Stein Eye Institute, Los Angeles, California

4:20 PM *Management of Diabetic Maculopathy*— Lawrence J. Singerman, M.D., Director, Fluorescein Angiography Laboratory at St. Luke's and Mt. Sinai Hospitals, Cleveland. Assistant Clinical Professor, Case Western School of Medicine, Cleveland

4:35 PM *Management of Proliferative Diabetic Retinopathy*— Stewart Krug, M.D., Cincinnati Retinal Associates, Clinical Instructor, Department of Ophthalmology, University of Cincinnati College of Medicine

4:50 PM *Panel Discussion*

OTOLARYNGOLOGY

CME Hours: 5 Category I
Date: Monday, May 12
Place: Room 203, Cincinnati Convention Center
Time: 8:45 AM - 4:30 PM
Sponsor: OSMA Section on Otolaryngology and Ohio Society of Otolaryngology

Schedule:

- 8:45 AM *Welcome*— S. George Lesinski, M.D., President, Ohio Society of Otolaryngology, Cincinnati
- 9:00 AM *Indications for Radical Neck Dissection*— Walter C. Bauer, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine and Surgical Pathologist-in-Chief, Barnes and Affiliated Hospitals, St. Louis, Missouri
- 9:45 AM Break
- 10:15 AM *Technique and Result of Radical Neck Dissection*— Edward C. Weisberger, M.D., Associate Professor, Department of Otolaryngology, University of Indiana, Indianapolis, Indiana
- 11:00 AM *Panel Discussion on Radical Neck Dissection*— Donald Shumrick, M.D., Moderator, Professor and Chairman, Department of Otolaryngology, University of Cincinnati Medical Center
Panel Members— Walter C. Bauer, M.D.; Edward C. Weisberger, M.D.; David E. Schuller, M.D., Assistant Professor, Otolaryngology, Ohio State

CME Courses (continued)

University, Columbus; and Jack L. Gluckman, M.D., Assistant Professor, Otolaryngology, University of Cincinnati Medical Center, Cincinnati

12 NOON *Luncheon*— Ivory A. Stouffer's Cincinnati Towers

1:30 PM *Etiology and Pathophysiology of Meniere's Disease*— Richard R. Gacek, M.D., Professor and Chairman, Department of Otolaryngology, Upstate Medical Center, Syracuse, New York

2:15 PM Break

2:45 PM *Treatment of Meniere's Disease*— Michael M. Paparella, M.D., Professor and Chairman, Department of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minnesota

3:30 PM *Panel Discussion on Meniere's Disease*— S. George Lesinski, M.D., *Moderator*, Associate Professor, Department of Otolaryngology, University of Cincinnati Medical Center; Richard R. Gacek, M.D.; Michael M. Paparella, M.D.; Sam Kenny, M.D., Cleveland Clinic, Cleveland; and Robert A. Goldenberg, M.D., Assistant Professor, Acting Chairman, Department of Otolaryngology, Wright State University, Dayton

4:30 PM Adjournment

PATHOLOGY

Date: Tuesday, May 13
Place: Rooms 205 & 207, Cincinnati Convention Center
Time: 9 AM - 4:30 PM
Sponsor: OSMA Section on Pathology and Ohio Society of Pathologists

Schedule: Program not complete at time of publication

PHYSICAL MEDICINE AND REHABILITATION

Date: Monday, May 12
Place: Room 215, Cincinnati Convention Center
Time: 1 - 4 PM
Sponsor: OSMA Section on Physical Medicine and Rehabilitation and Ohio Society of Physical Medicine and Rehabilitation

Schedule: Program not complete at time of publication

PLASTIC SURGERY

Topic: Management of Malignant Melanoma
CME Hours: 3 Category I
Date: Wednesday, May 14
Place: Room 202, Cincinnati Convention Center
Time: 9 AM - 12 Noon

Sponsor: OSMA Section on Plastic Surgery and Ohio Society for Plastic and Reconstructive Surgeons

Schedule:

9:00 AM *Introduction*— Henry W. Neale, M.D., Associate Professor of Surgery, Director, Division of Plastic, Reconstructive & Hand Surgery, University of Cincinnati Medical Center

9:10 AM *Moderator*— Dr. Neale
The Dermatologist and the Melanotic Lesion— Smith H. Gibson, M.D., Associate Clinical Professor of Dermatology, Department of Dermatology, University of Cincinnati Medical Center

9:30 AM *Pathologic Staging of Malignant Melanoma and Its Clinical Significance*— John Crissman, M.D., Associate Professor of Pathology, Department of Pathology, University of Cincinnati Medical Center

9:50 AM *Discussion*

10:00 AM *Moderator*— John W. Brogan, M.D., Assistant Clinical Professor of Surgery, Division of Plastic, Reconstructive & Hand Surgery, University of Cincinnati Medical Center
Surgical Approach to Malignant Melanoma— Richard O. Gregory, M.D., Assistant Professor of Surgery, Division of Plastic, Reconstructive & Hand Surgery, University of Cincinnati Medical Center; and Joel G. Kreilein, M.D., Plastic Surgery Resident, Division of Plastic, Reconstructive & Hand Surgery, University of Cincinnati Medical Center

10:20 AM *Value and Timing of Lymph Node Dissection in Malignant Melanoma*— William R. Culbertson, M.D., Professor of Surgery, Department of Surgery, University of Cincinnati Medical Center

10:40 AM *Discussion*

10:50 AM Break

11:00 AM *Moderator*— Dr. Neale
Congenital Melanoma— Its Origin and Treatment— John D. DesPrez, M.D., Professor of Plastic Surgery, Director, Division of Plastic Surgery of the University Hospitals, Case Western Reserve University, Cleveland

11:20 AM *Unusual Clinical Presentations of Melanomas*— John W. Brogan, M.D., Cincinnati

11:40 AM *Present State of Chemotherapy in the Treatment of Melanoma— Where Have We Been and Where Are We Going?*— Thomas L. Wright, M.D., Professor of Medicine, Department of Internal Medicine, University of Cincinnati Medical Center

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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CME Courses (continued)

12 NOON *Discussion*

12:15 PM *Luncheon*— Bronze A, Stouffer's Cincinnati Towers

PSYCHIATRY

Topic: Liaison Concepts: Psychiatry in the Medical-Surgical Millieu

CME Hours: 3 Category I

Date: Tuesday, May 13

Place: Room 217, Cincinnati Convention Center

Time: 1 - 4 PM

Sponsor: Ohio Psychiatric Association

Course Director: Neal E. Krupp, M.D., Chairman, Program and Continuing Education Committee, Ohio Psychiatric Association

Program:

Psychological Issues: The Patient with a Short Gut— A. Dale Gulledge, M.D., Head, Liaison Psychiatry, Department of Psychiatry, Cleveland Clinic Foundation

Psychosocial Management in Bone Marrow Transplantation— W. Terry Gipson, M.D., Cleveland Clinic, Cleveland

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The Impotent Patient: Functional Versus Organic
— Lawrence Martin, M.D., Cleveland Clinic, Cleveland

RHEUMATOLOGY

CME Hours: 3 Category I

Date: Monday, May 12

Place: Room 213, Cincinnati Convention Center

Time: 1:30 - 5 PM

Sponsor: OSMA Section on Rheumatology and Ohio Rheumatism Society

Course Director: Mahmood Pazirandeh, M.D., Program Chairman, Willoughby

Schedule:

12 NOON *Luncheon*— Bamboo B, Stouffer's Cincinnati Towers

1:30 PM *Introductory remarks*— Raymond Scheetz, M.D., President, Ohio Rheumatism Society, Cleveland

1:45 PM *Juvenile Rheumatoid Arthritis, Past and Present*— John Baum, M.D., Professor of Medicine, Pediatrics, and of Preventive, Family, and Rehabilitation Medicine, University of Rochester School of Medicine and Dentistry; and Director, Pediatric Arthritis Clinic at Strong Memorial Hospital, Rochester, New York

2:15 PM *Pathophysiology of Fibrositis*— William Wilke, M.D., Cleveland Clinic, Cleveland

2:45 PM *Connective Tissue Disease in the Elderly*— Robert I. Finkel, M.D., Clinical Assistant Professor of Medicine, Medical College of Ohio, Toledo

3:15 PM *Break*

3:30 PM *Modern Trends in the Treatment of Rheumatoid Arthritis*— Marvin H. Thomas, M.D., Clinical Assistant Professor, Department of Internal Medicine, Ohio State University College of Medicine, Columbus

4:00 PM *Hyperuricemia and Gout, Classic and New*— William E. Crowe, M.D., Assistant Professor, Medicine and Pediatrics, University of Cincinnati College of Medicine, Cincinnati

4:30 PM *Panel Discussion*

5:00 PM *Adjournment*

TRAUMA

Topic: Office and Emergency Room Management of Common Injuries

CME Hours: 3 Category I

Date: Wednesday, May 14

Place: Room 214, Cincinnati Convention Center

Time: 9 AM - 12 Noon

Sponsor: Ohio Committee on Trauma, A.C.S.

Course Director: *Richard Fratianne, M.D.*, President,
Ohio Committee on Trauma, A.C.S., Cleveland

Schedule:

9:10 AM *Management of Small Injuries of the Hand*
— Earl J. Fleegler, M.D., Cleveland

9:35 AM *Management of "Clean" Wounds*— John C.
Kelleher, M.D., Toledo

10:00 AM *Management of "Failed" Wounds*— Dr.
Kelleher and staff

10:25 AM Break

10:45 AM *Management of Common Fractures*— H. J.
Pompe van Meerdervoort, M.D., Professor of
Orthopaedic Surgery, Wright State University
School of Medicine, Dayton

11:10 AM *Management of Burns*— Robert L. Klein,
M.D., Attending Pediatric Surgeon, Akron Chil-
dren's Hospital Medical Center and The Akron
Regional Burn Center

11:35 AM *Panel Discussion*

Dialogue

PFIZER DIALOGUE PRESENTATION

CME Hours: 1 Category I (each presentation)

Date: Tuesday, May 13

Fee: None

Place: Room 202, Cincinnati Convention Center

Time: As designated

Sponsor: OSMA Committee on Scientific Work in
cooperation with Pfizer Pharmaceuticals

Schedule:

9:00 AM *Diagnosis and Management of Upper Res-
piratory Tract Infections*— J. Joseph Marr, M.D.,
Professor of Medicine, Director, Division of Infec-
tious Diseases, St. Louis University Hospital School
of Medicine, St. Louis, Missouri

11:00 AM *Role of the General Practitioner in Provid-
ing Ongoing Psychotherapy*— Thomas Cassidy,
M.D., Medical Director, Gallia, Meigs, Jackson
Community Mental Health Center, Gallipolis,
Ohio

1:00 PM *Drug Therapy in Asthma*— Irvin Caplin,
M.D., Associate Clinical Professor, Department of
Pediatrics, Indiana University School of Medicine,
Indianapolis, Indiana

2:15 PM *Film: The Clinical Significance of Coronary
Artery Spasm* (with accompanying monograph)

3:00 PM *Hypertension in the Diabetic Patient*—
Manuel Tzagournis, M.D., Professor of Medicine,
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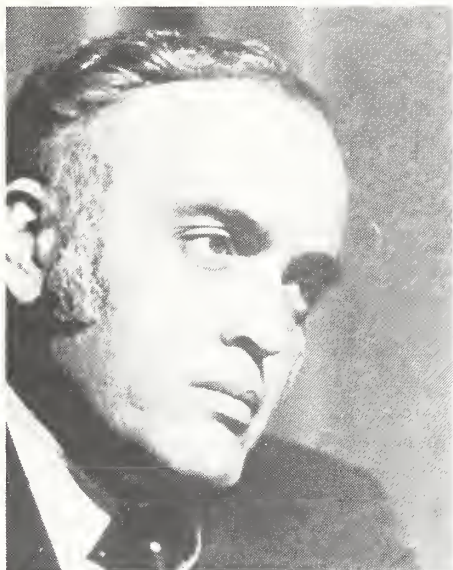


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OMPAC LUNCHEON

Washington Columnist to Speak on "Politics, 1980"



WHEN: Tuesday, May 13, 1980

WHERE: Grand Ballroom of Stouffer's Cincinnati Towers

TIME: 11:30 a.m., Social Period

12:00 Noon, Luncheon

SPEAKER: Robert D. Novak

Robert Novak is coauthor of the Washington column, "Inside Report," which is syndicated to over 250 newspapers here and abroad. A former chief congressional correspondent for the *Wall Street Journal*, Mr. Novak will address OMPAC members on "Politics, 1980." To reserve your space at the OMPAC luncheon, please use the form on page 258.

Cincinnati University Singers Will Entertain At Social Function



It only seems appropriate that since we are meeting in the Queen City, that we have our 1980 Social Function at the Queen City Club, 331 E. 4th Street, Cincinnati. The dinner Tuesday, May 13, will be preceded with cocktails at 6:30 p.m., dinner at 7:30 p.m., followed by entertainment of the magnificent "Cincinnati's University Singers." Cincinnati's University Singers is a dynamic show chorus of 28 talented young singing artists from the College-Conservatory of Music conducted by its music director, Dr. Earl Ribers, and choreographed by Ms. Joan Walton.

The program will feature an extended medley of music from the recordings and movies popularized by Barbra Streisand, selections from "My Fair Lady," production numbers from the current Broadway hit, "Ain't Misbehavin'," and jazz arrangements by Gene Puerling as recorded by the Singers Unlimited. New arrangements of songs by George Gershwin, Richard Rodgers, and Vincent Youmans, and the carols and madrigals of P. D. Q. Bach will also be presented.

Delegates and

Sunday, May 11

- 3 - 7 PM **Registration for OSMA House of Delegates**
Grand Ballroom Foyer, Stouffer's
- 4 PM **Councilor District Caucus Meetings**
(NOTE: Caucus suites will not be assigned prior meeting time— check location at registration desk.)
- 5:30 PM **Dinner for Delegates, Alternates, OSMA Council and Official Guests**
Bronze Rooms A & B, Stouffer's
- 7 PM **Opening Session, OSMA House of Delegates**
Grand Ballroom, Stouffer's

BUSINESS AGENDA

- Call to Order* Thomas W. Morgan, M.D., Gallipolis
OSMA President
- Invocation* Ronald K. Marmaduke, Elyria
Senior Minister
First Congregational Church
- Welcome* Richard B. Budde, M.D., Cincinnati
President, Academy of Medicine
of Greater Cincinnati
- Report* Committee on Credentials
- Consideration of Minutes of 1979 Annual Meeting*
(See July 1979 issue of *The Ohio State Medical Journal*)
- Introduction of AMA Board of Trustees Member*
H. Thomas Ballantine, Jr., M.D.,
Boston, Massachusetts
- Introduction of Member of the AMA Ad Hoc Committee on the Principles of Medical Ethics*
Carroll Witten, M.D., Louisville, Ky.
- Introduction of Honored Guests*
- PICO Report* George N. Bates, M.D., Toledo
Chairman of the Board of Trustees
The Physicians Insurance Co. of Ohio
- Report* Mrs. Monica Kaye, Mansfield
OSMA Auxiliary President
- Introduction of the Recipient of the AMA 1980 Distinguished Service Award*
Frank H. Mayfield, M.D., Cincinnati
- Presentation of the OSMA 1980 Distinguished Service Award*
Albert Sabin, M.D., Cincinnati
- Presentation of a Special Communications Award*
To Al Thielen, M.D., Cincinnati and
to WCPO-TV, Cincinnati
- AMA-ERF Presentations*
Philip B. Hardymon, M.D., Columbus
Chairman, Ohio Committee on
AMA-ERF

Presentation of Plaques

To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees.

Announcement

Thomas W. Morgan, M.D., Gallipolis
Appointments to the Reference, Credentials, President's Address, Resolutions, and Tellers and Judges of Election Committees.

Elections of Committee on Nominations

Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Wednesday, May 14, 3:30 PM, its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Seventh District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address

Thomas W. Morgan, M.D., Gallipolis



Introduction of Presidents of Other State Societies

Introduction of Resolutions

Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken.

Report of Ad Hoc Committee on Amended Res. 19-79 Update of OSMA Policy

James McLarnan, M.D., Mt. Vernon, Chairman,
Ad Hoc Committee

Miscellaneous Business

Wednesday, May 14

- 2:30 PM **Registration for OSMA House of Delegates**
Grand Ballroom Foyer, Stouffer's
- 3:30 PM **House of Delegates Final Session**
Grand Ballroom A & B, Stouffer's
- 6 PM **Dinner for Delegates, Alternates, OSMA**

Alternate Schedule

Council and Official Guests
Bronze Rooms A & B, Stouffer's

7 PM **Continuation of Final Session**
Grand Ballroom A & B, Stouffer's

BUSINESS AGENDA

Introduction of Guests

Presentation of Journal Photographic Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Election of Members of The Council

Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.

First District: Incumbent, Stewart B. Dunsker, Cincinnati; *Third District:* Incumbent, Alford C. Diller, Van Wert; *Fifth District:* Incumbent, Edward G. Kilroy, Cleveland; *Seventh District:* Incumbent, H. Judson Reamy, New Philadelphia; *Ninth District:* Incumbent, A. Burton Payne, Ironton; *Eleventh District:* Incumbent, S. Baird Pfahl, Jr., Sandusky.

Election of Delegates and Alternates to the AMA

Four Delegates and four Alternates to be elected for a two-year term starting January 1, 1981, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1980, their terms expiring December 31, 1980.

Delegates (listed alphabetically): Jerry L. Hammon, West Milton; H. William Porterfield, Colum-

bus; Jack Schreiber, Canfield; Robert N. Smith, Toledo.

Alternates: Alford C. Diller, Van Wert; Stewart B. Dunsker, Cincinnati; B. Leslie Huffman, Jr., Mau-



mee; Robert G. Thomas, Elyria.

All nominees for the offices of AMA Delegates and Alternate Delegates shall run at large. Election of Delegates and Alternates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

****SPECIAL ORDER OF BUSINESS** (after dinner break)
Installation of 1980-1981 Officers

Reports of Reference Committees

President's Address; Resolutions Committee No. 1; Resolutions Committee No. 2; Resolutions Committee No. 3.

Miscellaneous Business

Announcement

Robert G. Thomas, M.D., Elyria
OSMA President

Unfinished Business

Adjournment



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FRIEDRICH A. LINGL, M.D.
Medical Director

GUY H. WILLIAMS, JR., M.D.
Medical Director Emeritus

HERBERT A. SIHLER Jr.
President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

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Members of 1980 OSMA

By County: Delegates left column, Alternate Delegates right column.

First District

ADAMS COUNTY

Francis L. Stevens

BROWN COUNTY

John R. Donohoo

Gene F. Conway

BUTLER COUNTY

Gilbert J. Gordon

James M. Smith

Robert E. Stegemiller

Jack L. Harris

Michael A. Matthews

Marvin J. Russell

CLERMONT COUNTY

Carl A. Minning

Wm. Blake Selnick

CLINTON COUNTY

Foster J. Boyd

Edwin P. Hiatt

HAMILTON COUNTY

John E. Albers

Sanford Blank

Richard B. Budde

Harry H. Fox

Kenneth A. Frederick

William H. Gates

Robert S. Heidt

Harry K. Hines

Stephen P. Hogg

Stanley J. Lucas

Herbert G. Magenheimer

Richard L. Meyer

Thomas U. Todd

Lee J. Vesper

Walter B. Wildman II

Harold Pescovitz

John L. Thinnis

John H. Wulsin

Donald I. Radin

HIGHLAND COUNTY

Glenn B. Doan

Barbara Lustgarten

WARREN COUNTY

Thomas E. Fox

Gilbert K. Ohlhauser

Second District

CHAMPAIGN COUNTY

Isador Miller

John H. Flora

CLARK COUNTY

Henry A. Diederichs

Ernest H. Winterhoff

William Harper

Walter R. Lawrence

DARKE COUNTY

Alvan E. Thuma

Jesse L. Heise

GREENE COUNTY

R. Wm. Barry

Justin G. Krause

MIAMI COUNTY

A. Robert Davies

Jerry L. Hammon

MONTGOMERY COUNTY

Herman I. Abromowitz

John H. Boyles, Jr.

D. Kiefer Campbell

Robert K. Finley, Jr.

Frederic C. Schnebly

John R. Whitaker, Jr.

Gilbert W. Hopkins

Stephen T. House

Richard G. Jenkins

Sidney F. Miller

Kenneth P. Pohl

Walter A. Reiling, Jr.

PREBLE COUNTY

John D. Darrow

SHELBY COUNTY

George J. Schroer

Joseph Steurnagel

Third District

ALLEN COUNTY

Joseph M. Oppenheim

Gene E. Wright

Thomas Leech

Lawrence L. Young

AUGLAIZE COUNTY

David W. Nielsen

Elizabeth Y. Kuffner

CRAWFORD COUNTY

Johnson H. Chow

B. M. Mansfield

HANCOCK COUNTY

Chester L. Samuelson

Edwin B. Davis

HARDIN COUNTY

Robert B. Elliott

Leonard K. Smith

LOGAN COUNTY

James H. Steiner

Ray Nulson

MARION COUNTY

Paul E. Lyon

D. Lee Johnson

MERCER COUNTY

James J. Otis

Donald R. Fox

SENECA COUNTY

James A. Murray

J. F. Vela

VAN WERT COUNTY

Donald Walters

Jack Cox

WYANDOT COUNTY

Prasad Kakarala

Herschel A. Rhodes

Fourth District

DEFIANCE COUNTY

Allen Zimmer

Alan Gaspar

FULTON COUNTY

Benjamin H. Reed, Jr.

Vernon L. Cotterman

House of Delegates

HENRY COUNTY

Robert J. Blough

Thos. Francis Moriarty

LUCAS COUNTY

John A. Devany

Frank Foss

Roland A. Gandy, Jr.

B. Leslie Huffman, Jr.

James A. Jagodzinski

Thomas J. O'Grady

Peter A. Overstreet

Richard J. Wiseley

Donnan B. Harding, Jr.

John H. Hasley

Frederic C. Henry

Jerome Kimmelman

Howard S. Madigan

A. Arthur Mancini

Antonio B. Paat

Stanley T. Pinsky

OTTAWA COUNTY

John F. Bodie

Vincent Wm. Wagner

PAULDING COUNTY

Don K. Snyder

William Max Miller

PUTNAM COUNTY

James B. Overmier

John R. Brown

SANDUSKY COUNTY

Willis L. Damschroeder

Samuel R. Lowery

WILLIAMS COUNTY

John E. Moats

Robert W. Dilworth

WOOD COUNTY

Douglas S. Hess

Albert W. Smith III

Fifth District

ASHTABULA COUNTY

Stephen E. Gates

CUYAHOGA COUNTY

Felino V. Barnes

Donavin A. Baumgartner, Jr.

Matthew R. Biscotti

Donald F. Brittenum

Roland D. Carlson

Theodore J. Castele

James B. Daley

Nicholas G. DePiero

Richard B. Fratianne

Thomas E. Gretter

Henry G. Krueger

George P. Leicht

Leonard L. Lovshin

Leroy W. Matthews

Richard J. Nowak

John G. Poulos

Leonard P. Rome

Franklyn J. Simecek

Frederick T. Suppes

Warner W. Tuckerman

John M. Wilson

Robert J. White

Isidro J. Amigo

Antonio R. Antunez

Carl F. Asseff

Charles P. Bartley

Norman Bash

Dean H. Bernacchia

Gregory Collins

Dale H. Cowan

Gilbert H. Derian

Daniel A. Deutschman

Harvey J. Dworken

Parrish W. Garver

Shattuck W. Hartwell, Jr.

Nancy T. Johnson

John A. Kmieck

James A. MacKay

Valentin F. Mersol

James L. Phillips

Joseph Schultz

Peggy-Jeanne St. Clair

Albert M. Zippert

GEAUGA COUNTY

Bruce F. Andreas

Oscar A. Brinckmann

LAKE COUNTY

John A. Bukovnik

David L. Farrington

Harry A. Killian

Ronald J. Taddeo

Sixth District

COLUMBIANA COUNTY

William S. Banfield

Leonard S. Pritchard

MAHONING COUNTY

J. James Anderson

G. Robert Barton

P. J. Mahar, Jr.

Anthony T. Deramo

John C. Melnick

David E. Pichette

C. Edward Pichette

Joseph W. Tandatnick

William E. Sovik

Karl F. Wieneke

STARK COUNTY

Henry H. Clapper

George Ewing

E. Joel Davis

Richard A. Feezel

Edward E. Grable

Brian S. Harrold

Raymond J. McMahon, Jr.

David M. Montgomery

Reich L. Watterson, Jr.

James A. Niffenegger

TRUMBULL COUNTY

Joseph Sudimack, Jr.

Eduardo T. Angnardo

John O. Vlad

Rodolfo Ballesteros

Seventh District

BELMONT COUNTY

Nermin D. Lavapies

D. Birmingham

CARROLL COUNTY

Carl A. Lincke

Samuel L. Weir

COSHOCTON COUNTY

Robert R. Johnson

Norman L. Wright

HARRISON COUNTY

Elias Freeman

Janis Trupovnieks

JEFFERSON COUNTY

Augusto P. Fojas

Frank J. Petrola

MONROE COUNTY

Jack M. Matheny II

Donald R. Piatt

TUSCARAWAS COUNTY

Philip T. Doughten

Benjamin J. Wherley

Delegates (continued)

Eighth District

ATHENS COUNTY

John F. Kroner Kenneth D. Woods

FAIRFIELD COUNTY

James L. Barrett James A. Merk

GUERNSEY COUNTY

Robert A. Ringer William S. Quigley

LICKING COUNTY

John P. Anderson, Jr. Carl M. Frye

MORGAN COUNTY

Austin A. Coulson Henry Bachman

MUSKINGUM COUNTY

John W. Ray Benjamin Gilliotte

NOBLE COUNTY

Edward G. Ditch Frederick M. Cox

PERRY COUNTY

Alfredo Cruz Charles E. Bope

WASHINGTON COUNTY

Gregory B. Krivchenia Kenneth E. Bennett

Ninth District

GALLIA COUNTY

Thomas P. Price, Jr. Daniel H. Whiteley

HOCKING COUNTY

Rowan D. Labrador George T. Ralph

JACKSON COUNTY

John Wm. Zimmerly Carl J. Greever

LAWRENCE COUNTY

James B. Zimmerman John A. Mayer

MEIGS COUNTY

E. S. Villanueva Joseph J. Davis

PIKE COUNTY

Albert M. Shrader H. K. Giffin

SCIOTO COUNTY

Richard Villarreal Louis Chaboudy

VINTON COUNTY

Tenth District

DELAWARE COUNTY

David R. Smith, Jr. Thomas P. Hubbell

FAYETTE COUNTY

Robert U. Anderson

FRANKLIN COUNTY

Homer A. Anderson Benjamin Arnoff
Michael A. Anthony James W. Kilman

James E. Barnes
Joseph A. Bonta
Richard L. Fulton
Walter M. Haynes, Jr.
George W. Paulson
H. William Porterfield
Jack E. Tetirick

KNOX COUNTY

Henry T. Lapp

MADISON COUNTY

Sol Maggied

MORROW COUNTY

David James Hickson

PICKAWAY COUNTY

Ray Carroll

ROSS COUNTY

Joseph S. McKell

UNION COUNTY

John B. Ziegler

James F. Mason
James E. Matson
Paul S. Metzger
Alexander Pollack
Warren W. Smith
Robert L. Wall
J. Hutchison Williams

Roger H. Sherman

J. Richard Hurt

William S. Deffinger

Henry H. Swope

Eleventh District

ASHLAND COUNTY

Jon H. Cooperrider

Harold V. Marley

ERIE COUNTY

Richard H. Williamson

Arthur G. Groscost

HOLMES COUNTY

Luther W. High

Maurice E. Mullet

HURON COUNTY

Dennis Ross Irons

Nino M. Camardese

LORAIN COUNTY

John N. Bartone
Fred Hofman
Robert McFarland

Raymundo de la Pena
William H. Miller
Stephen M. Ticich

MEDINA COUNTY

Richard W. Avery

Rolland L. Mansell

RICHLAND COUNTY

Harold F. Mills
James W. Wiggin

James F. Clements
John L. Marquardt

WAYNE COUNTY

A. Burney Huff

John M. Robinson

Twelfth District

PORTAGE COUNTY

Robert Arnold

Alan Yoho

SUMMIT COUNTY

Rocco Antenucci
Charles A. East
Manley L. Ford
Aris W. Franklin
Paul D. Gatewood
Paul W. Kilway, Jr.
Francis J. Waickman

Charles V. Bowen, Jr.
Arthur Dobkin
Joseph L. Kloss
E. Gates Morgan
Robert T. Stone
Jack L. Summers
Abdon E. Villalba

OSMA OFFICERS

President	Thomas W. Morgan
President-Elect	Robert G. Thomas
Past President	John J. Gaughan
Secretary-Treasurer	David A. Barr

OSMA COUNCILORS

First District	Stewart B. Dunsker
Second District	Herman I. Abromowitz
Third District	Alford C. Diller
Fourth District	C. Douglass Ford
Fifth District	Edward G. Kilroy
Sixth District	Joseph P. Yut
Seventh District	H. Judson Reamy
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Resolutions Affecting OSMA

#23 Proposed Amendment to the Bylaws To Define Valid Ballots in Elections (Submitted by the OSMA Council)

WHEREAS, Delegates and alternate delegates to the American Medical Association have been chosen by a method of voting referred to by *Sturgis* (OSMA Parliamentary authority) as "Simultaneous election of candidates to several positions of equal rank"; and

WHEREAS, Thomas W. Morgan, M.D., President of OSMA, appointed an Ad Hoc Committee to evaluate the OSMA House of Delegates voting procedure; and

WHEREAS, Examination and careful scrutiny by the Ad Hoc Committee of the ballots from the 1979 OSMA House of Delegates Annual Meeting demonstrated significant intent and potential for influencing the results of multiple candidate elections; THEREFORE BE IT

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended by adding at the end of the third and last paragraph the following:

"No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee." (For example: If upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for four (4) of the nominees for such positions.)

#24 Establishment of Councilor Districts (Submitted by the OSMA Council)

RESOLVED, That Chapter 4, Section 6, of the Bylaws of the Association be amended to provide as follows:

"The House of Delegates shall establish councilor districts. The districts shall comprise one or more contiguous counties. A district society may be organized in any of the councilor districts to meet at such time or times as such society may fix."

#33 Proposed Amendment to the Bylaws to Change Titles of the Standing Committees (Submitted by the OSMA Council)

WHEREAS, The titles of the Standing Committees of the Ohio State Medical Association should reflect the purposes and functions of the Committee, THEREFORE BE IT

RESOLVED, That Chapter 9, Section 1, of the Bylaws of the Ohio State Medical Association be amended to read as follows:

1. Committee on Communications, 2. Committee on Program, 3. Committee on Education, 4. Committee on Judicial and Professional Relations, and 5. Committee on Membership.

#25 Representation of Specialty Societies in OSMA Delegations (Submitted by Academy of Medicine of Cleveland Endorsed by Fifth District Delegation)

WHEREAS, There is an increasing tendency for physicians to relate to their respective specialty societies on local, state and national level including the American Association of Family Practice and the Ohio Association of Family Physicians, and

WHEREAS, There is a need for the particular viewpoint of the various disciplines in the deliberations of organized medicine, especially in the area of socioeconomics and practice, THEREFORE BE IT

RESOLVED, That a mechanism be developed by the OSMA Council for constitutional changes to affect direct representation of the specialty societies in the House of Delegates of the OSMA.

#28 Semiannual Meetings of OSMA House of Delegates (Submitted by Academy of Medicine of Cleveland Endorsed by Fifth District Delegation)

WHEREAS, The accelerated pace of legislative action by governmental bureaus, third party insurers, other health providers, and the process of change within medical practice itself require major policy decisions more frequently than once yearly, and

WHEREAS, The OSMA House of Delegates holds the authority for policy decisions for the OSMA and delegates that authority to Council for action between sessions, and

WHEREAS, The membership will be better served by more timely attention to policy issues by the entire House of Delegates; THEREFORE BE IT

RESOLVED, That constitutional changes be enacted to enable the House of Delegates to meet in business sessions at least 30 days prior to both the Annual and Interim sessions of the AMA.

FISCAL NOTE: Cost could range from \$5000 to \$60,000 depending upon the structure of the meeting.

#34 Voting for AMA Delegates and Alternate Delegates (Submitted by Academy of Medicine of Cleveland Endorsed by Fifth District Delegation)

A Constitution and Bylaws

WHEREAS, Not all members of the Ohio State Medical Association are members of the American Medical Association; and

WHEREAS, Only members of an association should be entitled to elect representatives to that association, and

WHEREAS, Delegates to the Ohio State Medical Association Annual Meeting are not required to be members of the American Medical Association; and

WHEREAS, Delegates to the Ohio State Medical Association Annual Meeting elect Delegates and Alternate Delegates to the American Medical Association, THEREFORE BE IT

RESOLVED, That Chapter 4, Section 5 of the Bylaws of OSMA be amended to require that only those Delegates to the Ohio State Medical Association Annual Meeting who are members of the American Medical Association shall be eligible to cast a ballot in the election of Ohio representatives to the American Medical Association.

#35 Full Voting Privileges for Medical Students and Residents (Submitted by Academy of Medicine of Cleveland Endorsed by Fifth District Delegation)

WHEREAS, The future strength of medical organizations is dependent upon informed and involved members; and

WHEREAS, It is desirable to encourage medical students and residents to recognize not only the benefits they receive from organized medicine but, also, the importance of their individual contributions; and

WHEREAS, The active involvement of medical students and residents would further stimulate free and open discussion of topics from varied perspectives, THEREFORE BE IT

RESOLVED, That the Council of OSMA develop a mechanism for changes in the Constitution and By-laws of OSMA which would result in an equitable and appropriate method for direct representation in the House of Delegates of physicians-in-training and medical students.

#26 Medical Specialty Representation In OSMA House of Delegates (Submitted by OSMA Council)

WHEREAS, Many issues concern all medical societies and medical specialties within the family of medicine, and

WHEREAS, Achievement of common goals by medical societies requires close cooperation and coordination; and

WHEREAS, There is currently no official mechanism for input in regard to matters specifically and particularly affecting a medical specialty; THEREFORE BE IT

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended to provide for Medical Specialty representation in the House of Delegates as follows:

Chapter 4. The House of Delegates **Section 3. Representation of Medical Specialties:**

A Medical Specialty, defined as a member organization of the American Board of Medical Specialties as listed in the current edition of Directory of Medical Specialties, is eligible to apply for representation in the House of Delegates.

The physicians represented by this specialty

- (a) Must number at least 50, and
- (b) At least 50% of these physicians must be members of the Ohio State Medical Association for the first year of representation; 60% the second year; and 75% the third year and for each year thereafter.

A Medical Specialty seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the applicant specialty qualifies for representation. In the event that more than one application is made for a given specialty, the House of Delegates will determine which group shall be designated.

Each recognized Medical Specialty shall have one delegate and alternate who must be members of the Ohio State Medical Association. Each specialty will certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate, and its membership certification as required by subsection (b) above. A Medical Specialty delegate shall have all rights, privileges and duties as other delegates.

Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates, AND BE IT FURTHER

RESOLVED, That the remaining sections of Chapter 4 be renumbered accordingly beginning with Quorum as Section 4.

#38 Single Membership for Organized Medicine (Submitted by Fifth District Delegation)

WHEREAS, The problems of medical practice must be addressed on local, state, and national levels, and

WHEREAS, Each physician benefits from the activities of organized medicine at all levels, and

WHEREAS, Only 31.3% of physicians bear the burden for activities at the national level while approxi-

Resolutions (continued)

mately 70% of physicians support the local and state organization, THEREFORE BE IT

RESOLVED, That the OSMA House of Delegates indicate to the AMA the desirability for such constitutional changes in OSMA and AMA which would result in a single unified membership for all three levels of organized medicine, and BE IT FURTHER

RESOLVED, That such action not seriously disrupt the present structure of the AMA as a federation of component state medical societies or the Ohio State Medical Association as a federation of component county medical societies.

#39 Limitation of Service on AMA Delegation (Submitted by Academy of Medicine of Cleveland)

WHEREAS, The influence of incumbency on the elective process mitigates against change in the makeup of the AMA delegation, and

WHEREAS, Human nature is not predisposed to voluntarily relinquish a position of importance, and

WHEREAS, The goals of organized medicine are better served by periodic infusion of fresh and innovative approaches, THEREFORE BE IT

RESOLVED, That the duration of services of a member of the AMA delegation of Ohio Medical Association not exceed twelve years.

#36 Election of Officers (Submitted by John H. Boyles, M.D., Delegate, Montgomery County)

WHEREAS, The membership of OSMA and the AMA has steadily decreased over the past few years; and

WHEREAS, The OSMA allegedly wants more grass roots participation by its membership; and

WHEREAS, There is little opportunity for the membership to express their feeling to the hierarchy of OSMA and AMA, THEREFORE BE IT

RESOLVED, That the officers of the OSMA be elected by a ballot of the membership rather than by a ballot of the House of Delegates; and BE IT FURTHER

RESOLVED, That the AMA delegation seek a similar type of action in the next AMA meeting.

#29 Interim Sessions of the OSMA House of Delegates (Submitted by Sixth District Delegation)

WHEREAS, The pace of medical progress, as well

as the volatile political atmosphere has been greatly accelerated in the past ten years; and

WHEREAS, The American Medical Association has recognized this fact and now holds an interim session of its House of Delegates on an annual basis . . . a meeting which has become increasingly important . . . so much so, that business conducted at this interim session is of the same importance and magnitude as that conducted at the annual session; and

WHEREAS, Many states have recognized the advantage of having a session of their House of Delegates within sixty days of the interim session of the House of Delegates of the AMA, thus giving them the opportunity of introducing current and/or timely resolutions; and

WHEREAS, Those states not having such sessions find themselves bound by instructions and/or directives which may be outdated; THEREFORE BE IT

RESOLVED, That the House of Delegates of the OSMA meet in interim policy-making session not less than thirty nor more than sixty days prior to the interim session of the House of Delegates of the AMA; and BE IT FURTHER

RESOLVED, That such meeting be held in Columbus, Ohio with a Friday P.M. commencement and an adjournment no later than the Sunday P.M. immediately following the commencement of said session.
Fiscal Note: (Estimated cost \$3,500-5,000)

#27 Specialty Society Representation in OSMA (Submitted by Academy of Medicine of Cincinnati)

WHEREAS, The medical profession is confronted with the ever-increasing impact of government intervention and control; and

WHEREAS, The OSMA has always taken the lead in legislative action in Ohio as well as maintaining a direct link to the AMA and its Washington legislative activity to aid its members in adhering to high quality medical standards; and

WHEREAS, Accomplishment of the goal of perpetuating the highest caliber of medicine requires unity among all physicians and organizations with emphasis on resolving differences to achieve solidarity of our aims and intentions; and

WHEREAS, No other forum offers the membership the broad span of goals which already embrace members of specialty and subspecialty organizations; THEREFORE BE IT

RESOLVED, That the OSMA accept one delegate and one alternate delegate as a member of its House of Delegates with full voting privileges from each AMA recognized specialty and subspecialty organization. This delegate would be elected by the organization which he

(continued on page 252)

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MAY 10-14

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County Society Officers, Executive Directors and Meeting Dates

First District

Councilor: *Stewart B. Dunsker, M.D.*, 506 Oak Street, Cincinnati 45219.

ADAMS: Gary Greenlee, M.D., President, 33 E. Second St., Manchester 45144; David E. Pixley, M.D., Secretary-Treasurer, 154 E. Elliott Ave. Peebles 45660. Second Tuesday.

BROWN: Antonio P. Mendoza, M.D., President, 120 E. Plane St., Bethel 45106; Dhanemkula Mohangandhi, M.D., Secretary-Treasurer, 14 N. Second St., Ripley 45167. First or second Sunday.

***BUTLER:** John M. Evans, M.D., President, 685 Tari Lane, Hamilton 45013; Robert A. Love III, M.D., Secretary-Treasurer, 7 Lisa Dr., Hamilton 45013; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Fourth Wednesday, September-May except December.

CLERMONT: Robert A. Baker, M.D., President, 524 W. Main St., Williamsburg 45176; William Blake Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Ave., Loveland 45140. Third Wednesday except July, August and December.

CLINTON: Roy D. Goodwin, M.D., President, 12 N. Lincoln St., Wilmington 45177; Pushpa L. Makkar, M.D., Secretary-Treasurer, 2754 Pleasant Run, Xenia 45385. Fourth Tuesday.

***HAMILTON:** Richard B. Budde, M.D., President, 506 Oak St., Cincinnati 45219; Walter B. Wildman II, M.D., Secretary, 199 Lafayette Circle, Cincinnati 45220; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday except August.

HIGHLAND: Barbara Lustgarten, M.D., President, 1440 N. High St., Box 511, Hillsboro 45133; Glenn B. Doan, M.D., Secretary-Treasurer, 528 South St., Greenfield 45123.

WARREN: Thomas E. Fox, M.D., President, 309 Reading Rd., Mason 45040; Ray E. Simendinger, M.D., Secretary, 901 N. Broadway, Lebanon 45036. Second Tuesday.

Second District

Councilor: *Herman I. Abromowitz, M.D.*, 226 Troy St., Dayton 45404.

CHAMPAIGN: Barry Paxton, M.D., President, 900 Scioto St., Urbana 43078; James B. Hall, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second or third Wednesday.

CLARK: Thomas M. Board, M.D., President, 204 S. Belmont Ave., Springfield 45505; William C. Fippin, M.D., Secretary, 8943 Wildlane Dr., South Charleston 45368; Colleen Buscemi, Executive Secretary, 1002 N. Fountain Ave., Springfield 45504, 513/324-8618. Third Monday, September-May.

DARKE: John P. Studebaker, M.D., President, 220 Martz, Greenville 45331; Jesse L. Heise, M.D., Arcanum Medical Center, Arcanum 45304. Third Tuesday.

GREENE: Shamin A. Shamsi, M.D., President, Greene Memorial Hospital-Pathology, Xenia 45385; Manoj Desai, M.D., Secretary-Treasurer, 1042 Kauffman, Fairborn 45324; Mrs. Virginia Jones, Executive Secretary, 761 Buckskin Trail, Xenia 45385, 513/376-3783. Third Thursday.



MIAMI: Warren Kaebnick, M.D., President, 57 Robinhood Lane, Troy 45373; Peter E. Nims, M.D., Secretary, 27 Robinhood Lane, Suite 2, Troy 45373. First Tuesday.

MONTGOMERY: Sylvan L. Weinberg, M.D., President, 500 IBM Bldg., Dayton 45402; Howard Abrams, M.D., Secretary, 226 Troy St., Dayton 45404; Richard G. Tapia, Executive Director, 40 S. Perry St., Suite 100, Dayton 45402, 513/223-1431. Fourth Thursday.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 101 Edgewood Dr., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 20 S. Main St., Ft. Loramie 45845; Jerome Mestemaker, M.D., Secretary-Treasurer, 322 Second Ave., Sidney 45365. Second Tuesday.

County Officers (continued)

Third District

Councilor: *Alford C. Diller, M.D.*, Medical Arts Bldg., 140 Fox Rd., Van Wert 45891.

***ALLEN:** John D. Albertson, M.D., President, 1893 Idlewood Dr., Lima 45805; Roger L. Terry, M.D., Secretary-Treasurer, 1220 E. Elm St., Suite 110, Lima 45804; Will Wolf, Executive Secretary, Box 1647, Lima 45802, 419/228-3335. Third Tuesday, September-May.

AUGLAIZE: James R. Romaker, M.D., President, 114 W. Main St., Lima 45806; Thomas C. Dozier, M.D., Secretary-Treasurer, 112 S. Court St., St. Marys 45885. First Thursday, January, March, May, September and November.

CRAWFORD: Robert N. Agee, M.D., President, 108 S. Market St., Galion 44833; Dale C. Angerman, M.D., Secretary-Treasurer, 270 Portland Way S., Galion 44833.

HANCOCK: Roy E. Hutchison, M.D., President, 1816 Chapel Dr., #J, Findlay 45840; A. G. Angustia, M.D., Secretary, 1804 Cherry Lane, Findlay 45840. Third Tuesday.

HARDIN: Jay E. Pfeiffer, M.D., President, 900 E. Franklin St., Kenton 43326; Jose G. Guzman, M.D., Secretary-Treasurer, 777 May Doll Dr., Kenton 43326. Second Tuesday.

LOGAN: Charles L. Barrett, M.D., President, 119 S. Madriver St., Bellefontaine 43311; Thomas C. Franklin, M.D., Oakhill Medical Associates, Route 2, West Liberty 43357. Five meetings per year, generally January, March, May, September and November.

***MARION:** Kazi Mobin-Uddin, M.D., President, 1040 Delaware Ave., Marion 43302; Leonard Janchar, M.D., Secretary-Treasurer, 1040 Delaware Ave., Marion 43302. First Tuesday, September-May.

MERCER: Donald R. Fox, M.D., President, 118 W. Fulton St., Celina 45822; George H. McIlroy, M.D., Secretary-Treasurer, 123 E. Fayette St., Celina 45822. Third Tuesday.

SENECA: Azael P. Borromeo, M.D., President, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830; Horst R. Niemann, M.D., Secretary-Treasurer, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830. Third Tuesday except July, August and December.

VAN WERT: Donald E. Hughes, M.D., President, Van Wert County Hospital, 1250 S. Washington St., Van Wert 45891; James L. Evans, M.D., Secretary-Treasurer, 140 Fox Rd., Van Wert 45891.

WYANDOT: Prasad Kakarala, M.D., President, Wyandot Memorial Hospital, Upper Sandusky 43351; Donald P. Smith, M.D., Secretary-Treasurer, Wyandot Memorial Hospital, Upper Sandusky 43351. Second Tuesday.



Fourth District

Councilor: *C. Douglass Ford, M.D.*, 2361 W. Bancroft St., Toledo 43607.

DEFIANCE: Charles E. Jaeckle, M.D., President, Route 7, Defiance 43512; K. G. Srinivas, M.D., Secretary-Treasurer, Defiance Clinic, 1400 E. Second St., Defiance 43512. Second Tuesday.

FULTON: Benjamin H. Reed, Jr., M.D., President, 101 Adrian St., Delta 43515; Estela T. Miquiabas, M.D., Secretary-Treasurer, Fulton County Health Center, 725 S. Shoop Ave., Wauseon 43567. Second Tuesday, quarterly.

HENRY: Robert J. Blough, M.D., President, 141 N. Keyser Ave., Deshler 43516; Raymond J. Manahan, M.D., Secretary-Treasurer, 1325 Woodlawn Ave., Napoleon 43545. First Tuesday.

LUCAS: Walter H. Hartung, Jr., M.D., President, 2600 Navarre, Oregon 43616; Richard T. Torchia, M.D., Secretary, 4235 Secor Rd., Toledo 43623; Lee F. Wealton, Executive Director, Secor Professional Bldg., 4428 Secor Rd., Toledo 43623, 419/473-3200. Fourth Tuesday (Council).

OTTAWA: V. William Wagner, M.D., President, 105 Madison St., Port Clinton 43452; Robert S. Reeves, M.D., Secretary-Treasurer, 504 E. Water St., Oak Harbor 43449. Second Thursday, October-June.

PAULDING: Donald K. Snyder, M.D., President, R.D. #2, Payne 45880; Kirkwood A. Pritchard, M.D., Secretary-Treasurer, 119 S. Main, Paulding 45879. Third Monday.

PUTNAM: Oliver N. Lugibihl, M.D., President, Box 235, Pandora 45877; Kachun Wong, M.D., Secretary-Treasurer, Box 295, Pandora 45877. First Tuesday.

SANDUSKY: P. I. Mathew, M.D., President, 1922 Glen Springs Dr., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memo-

rial Hospital of Sandusky County, Fremont 43420, 419/332-7321. Quarterly.

WILLIAMS: Donald Cameron, M.D., President, 442 W. High St., Bryan 43506; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506; Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, 419/636-4517. Third Tuesday, January, March, May, September and November.

WOOD: Marjorie E. Conrad, M.D., President, 15819 Bowling Green Rd. W., Bowling Green 43402; Richard D. Barker, M.D., Secretary-Treasurer, 960 W. Wooster, Bowling Green 43402. Third Thursday.

Fifth District

Councilor: *Edward G. Kilroy, M.D.*, 20800 Westgate Ct., Cleveland 44126.

ASHTABULA: Samuel Kerneklian, M.D., President, Ashtabula General Hospital, 2420 Lake Ave., Ashtabula 44004; Arthur P. Holstein, M.D., Secretary-Treasurer, 129 Roosevelt Dr., Geneva 44041; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday, February, April, September, November and December.

***CUYAHOGA:** Donavin A. Baumgartner, Jr., M.D., President, 6803 Mayfield Rd., Mayfield Heights 44124; Roland D. Carlson, M.D., Secretary-Treasurer, 29001 Cedar Rd., Cleveland 44124; Robert A. Lang, Ph.D., Executive Director, University Circle Research Bldg. #2, Sixth Floor-Penthouse, 11001 Cedar Rd., Cleveland 44106, 216/229-2200.

GEAUGA: David C. Mayer, M.D., President, 13221 Ravenna Rd., Chardon 44024; Arturo Dimaculangan, M.D., Secretary-Treasurer, 13346 Ravenna Rd., P.O. Box 277, Chardon 44024; Mrs. Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday except July and August.

LAKE: Armin J. Green, M.D., President, 8224 Mentor Ave., Mentor 44060; Donald M. Patchin, M.D., Secretary-Treasurer, 8451 Mentor Ave., Mentor 44060; Mrs. Marge McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060, 216/255-2233. February, May, September and November.



Sixth District

Councilor: *Joseph P. Yut, M.D.*, 201 Dueber Ave., S.W., Canton 44706.

COLUMBIANA: Manolo P. Mapa, M.D., President, 129 W. Fourth St., East Liverpool 43920; I. Sreeniva Rao, M.D., Secretary-Treasurer, 7941 State Route 45, Lisbon 44432; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, 216/337-8859. Third Tuesday.

MAHONING: B. Patrick Brucoli, M.D., President, 5204 Mahoning Ave., Suite 104, Youngstown 44515; H. S. Wang, M.D., Secretary, 10 Dutton Dr., Youngstown 44502; Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, 216/747-4956. Third Tuesday, January, March, May, September, November and December.

STARK: Walter J. Telesz, M.D., President, 420 Lake Ave., N.E., Massillon 44646; Guillermo R. Sicard, M.D., Secretary-Treasurer, 515 Third St., N.W., Canton 44703; Nancy Adams, Executive Secretary, 4150 Belden Village St., N.W., Canton 44718, 216/492-3333. Second Thursday, October-April.

TRUMBULL: Meredith E. Sorrell, M.D., President, 1819 Elm Rd., N.E., Warren 44483; Michael J. Casale, M.D., Secretary-Treasurer, 2390 Parkman Rd., N.W., Warren 44485; Mrs. Delores B. Bevan, Executive Secretary, 280 N. Park Ave., Warren 44481, 216/394-4556. Third Wednesday.

Seventh District

Councilor: *H. Judson Reamy, M.D.*, 931 Fourth St., N.W., New Philadelphia 44663.

BELMONT: Nermin D. Lavapies, M.D., President, 1220 Hughes Ave., Martins Ferry 43935; Lois R. Zimmerman, M.D., Secretary-Treasurer, 110 Walnut Ave., St. Clairsville 43950. Third Thursday, February, March, April, June, September, October, November and December.

CARROLL: Jack L. Maffett, M.D., President, 264 S. Lisbon St., Carrollton 44615; Jon H. Marshall, D.O., Secretary-Treasurer, 276 Second St., S.W., Carrollton 44615. Third Tuesday.

COSHOCTON: Jiniae D. Kim, M.D., President, 406 S. Fifteenth St., Coshocton 43812; Myron Satsurski, M.D., Secretary-Treasurer, 149 S. Bridge St., Newcomers-town 43832. Second Tuesday.

HARRISON: Ajit S. Modi, M.D., President, R.D. 1, Cadiz 43907; Siripurapu R. Prasad, M.D., Secretary-Treasurer, Main St., Box 323, Jewett 43986. Second Tuesday.

County Officers (continued)

JEFFERSON: Sadri Alavi, M.D., President, 517 N. Fourth St., Steubenville 43952; Enrique G. Macias, M.D., Secretary-Treasurer, 2017 Sunset Blvd., Steubenville 43952. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Route 3, Old Airport Rd., Woodsfield 43793. First Wednesday of every month.

TUSCARAWAS: Loreto R. Dacio, M.D., President, 533 N. Wooster Ave., Dover 44622; Bharat Oza, M.D., Secretary, 330 N. Water St., Uhrichsville 44683. Second Wednesday.

Eighth District

Councilor: *Carl E. Spragg, M.D.*, 71 W. Main St., New Concord 43762.

ATHENS: Kenneth D. Woods, D.O., President, 16 Ball Dr., Athens 45701; Lester A. Hamilton, M.D., Secretary-Treasurer, 400 E. State St., Athens 45701. Second Tuesday, March, June, September and December.

FAIRFIELD: Harold J. Schwendeman, M.D., President, Route 5, Lancaster 43130; John G. O'Handley, M.D., Secretary-Treasurer, 600 Pleasantville Rd., Lancaster 43130. Second Tuesday.

GUERNSEY: Nila Z. Sayat, M.D., President, 64979 Old Route 21, R.D. #3, Cambridge 43725; A. R. Srikanthiah, M.D., Secretary-Treasurer, 1330 Clark St., Cambridge 43725. First Tuesday except July and August.

LICKING: Pattye A. Whisman, M.D., President, 1320 W. Main St., Newark 43055; David C. W. Suh, M.D., Secretary-Treasurer, 1320 W. Main St., Newark 43055; Mrs. Lindsay Freytag, Executive Secretary, 1320 W. Main St., Newark 43055, 614/344-0331, Ext. 394. Fourth Thursday except June, July, August, December.

MORGAN: Asia H. Whitacre, M.D., President, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM: Walter K. Chess, M.D., President, 8 S. Layton Dr., New Concord 43762; Ross E. Williams, M.D., Secretary-Treasurer, 2835 Maple Ave., Zanesville 43701. First Tuesday.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Michael P. Clouse, M.D., President, Clouse

Clinic, W. Main St., Somerset 43783; Ralph E. Herendeen, Jr., M.D., Secretary-Treasurer, 203 N. Main St., New Lexington 43764.

WASHINGTON: William Jacoby, M.D., President, Marietta Memorial Office Bldg., Marietta 45750; Aniano B. DeJosef, M.D., Secretary-Treasurer, Marietta Memorial Hospital, Marietta 45750. Second Wednesday.

Ninth District

Councilor: *A. Burton Payne, M.D.*, 411 Center St., Ironton 45638.

GALLIA: Restituto H. Alonzo, M.D., President, Holzer Clinic, Ltd., P.O. Box 344, Gallipolis 45631; J. Craig Strafford, M.D., Secretary-Treasurer, Holzer Clinic, Ltd., P.O. Box 344, Gallipolis 45631. Second or third Tuesday, February, May, August and November.

HOCKING: Rowan D. Labrador, M.D., President, Route 5, Box 305, Logan 43138; John E. Rauch, D.O., Secretary-Treasurer, 207 Falls, Logan 43138.

JACKSON: John W. Zimmerly, M.D., President, Route 1, Box 299-A, Jackson 45640; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Vallee Blagg, M.D., President, 1805 S. Fourth St., Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 2412 S. Sixth St., Ironton 45638. Second Thursday quarterly.

MEIGS: Selim J. Blazewicz, M.D., President, P.O. Box 511, Pomeroy 45769; Wilma A. Mansfield, M.D., Secretary-Treasurer, P.O. Box 207, Pomeroy 45769.

PIKE: Kenneth A. Wilkinson, M.D., President, Hilltop Medical Center, Route #2, Waverly 45690; Darrell K. Wells, M.D., Secretary-Treasurer, 216 Emmitt Ave., Waverly 45690.

SCIOTO: George F. White, M.D., President, 1711 27th St., Portsmouth 45662; Doyle E. Campbell, M.D., Secretary-Treasurer, 1715 27th St., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, 614/354-7581. Second Tuesday.

VINTON: No active society.

Tenth District

Councilor: *J. Hutchison Williams, M.D.*, 4355 Sharon Ave., Columbus 43214.

DELAWARE: Richard C. Orahod, M.D., President, 90 E. William St., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 6 S. Main St., Magnetic Springs 43036. Third Tuesday, March, May, September and December.

FAYETTE: Hugh W. Payton, M.D., President, 36



S. Main St., Jeffersonville 43128; Marvin H. Roszmann, M.D., Secretary-Treasurer, P.O. Box 547, Washington Court House 43160. Second Friday.

FRANKLIN: J. Richard Briggs, M.D., President, 423 E. Town St., Columbus 43215; George T. Harding, Jr., M.D., Secretary-Treasurer, 445 E. Granville Rd., Worthington 43085; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, 614/224-6116. February, August, September and October.

***KNOX:** Donald V. Walz, M.D., President, Knox Community Hospital East, Mount Vernon 43050; Herbert M. Sinton, M.D., Secretary-Treasurer, 307 Verne-dale Dr., Mount Vernon 43050. First Wednesday.

MADISON: Martin Markus, M.D., President, 112 E. High St., London 43140; Sol Maggied, M.D., Secretary-Treasurer, 15 E. Pearl St., West Jefferson 43162. Four meetings a year.

MORROW: David J. Hickson, M.D., President, Box 208, Mount Gilead 43338; Joseph P. Ingmire, M.D., Secretary-Treasurer, 28 W. High St., Mount Gilead 43338. First Tuesday.

PICKAWAY: William A. Myers, M.D., President, 610 Northridge Rd., Circleville 43113; Michael E. Geron, M.D., Secretary-Treasurer, Circleville Medical Associates, 111 Island Rd., Circleville 43113. Second Tuesday except July and August.

ROSS: Lowell D. Smith, M.D., President, 612 Central Center, Chillicothe 45601; Numeriano Jalbueno, Jr., M.D., Secretary-Treasurer, 207 Delano Ave., Chillicothe 45601. Second Tuesday.

UNION: John B. Ziegler, M.D., President, 18522 Raymond Rd., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday, February, April, October and December.

Eleventh District

Councilor: *S. Baird Pfahl, Jr., M.D.*, 521 W. Perkins Ave., Sandusky 44870.

ASHLAND: Varalakshmi Dheenani, M.D., President, 203 Maple St., Ashland 44805; Young C. Shin, M.D., Secretary-Treasurer, 350 Hillcrest Dr., Ashland 44805. First Tuesday.

ERIE: Charles J. Everett, M.D., President, 3207 Campbell St., Sandusky 44870; Douglas C. Rist, M.D., Secretary-Treasurer, 2528 Columbus Ave., Sandusky 44870. Mrs. David Wolfert, Executive Secretary, Scheid Rd., Box 381-E, Huron 44839, 419/433-3097. Second Tuesday except July and August.

HOLMES: Charles H. Hart, M.D., President, 109 S. Clay St., Millersburg 44654; William V. Dugan, M.D., Secretary-Treasurer, Joel Pomerene Memorial Hospital, Millersburg 44654. Second Monday.

HURON: Shan A. Mohammed, M.D., President, 3 Milan Manor Dr., Milan 44846; Carl D. Obenauf, M.D., Secretary-Treasurer, 266 Benedict Ave., Norwalk 44857. Second Wednesday, February, April, June, October and December.

LORAIN: Francisco S. Floro, M.D., President, 863 Princeton Circle, Amherst 44001; Joseph Sciarrotta, M.D., Secretary-Treasurer, 2100 Reid Ave., Lorain 44052; Mrs. Alice Waite, Executive Secretary, 1480 N. Ridge Rd., E., Elyria 44035, 216/324-3093 or 233-6561. Second Tuesday, September-April.

MEDINA: Michael A. Bianco, M.D., President, 251 Leatherman Rd., Wadsworth 44281; James K. McAleer, M.D., Secretary-Treasurer, 740 E. Washington St., Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256. Third Thursday.

RICHLAND: John A. Savoy, M.D., President, 222 Marion Ave., Mansfield 44903; Albert H. Voegele, M.D., Secretary-Treasurer, 240 Park Ave. West, Mansfield 44902; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, 419/522-3411. Third Thursday, September-May.

WAYNE: H. Richard Slagle, M.D., President, 1874 Cleveland Rd., Wooster 44691; Owen W. Logee, M.D., Secretary-Treasurer, 1874 Cleveland Rd., Wooster 44691. Second Wednesday.

Twelfth District

Councilor: *William Dorner, Jr., M.D.*, 750 W. Market St., Akron 44303.

PORTAGE: James J. Waugh, M.D., President, 155 N. Water St., Kent 44240; Atila N. Can, M.D., Secretary-Treasurer, 152 N. Water St., Kent 44240. Second Tuesday.

SUMMIT: Robert T. Stone, M.D., President, 300 Locust St., Akron 43302; E. Gates Morgan, M.D., Secretary, 1200 Firestone Pkwy., Akron 44317; S. H. Mountcastle, Managing Director, 430 Grant St., Akron 44311, 216/434-1921. First Tuesday, January, March, May, July, September and November.

* These counties change officers between May and September.

Resolutions (continued)

represents at the OSMA House of Delegates Meeting; and, **BE IT FURTHER**

RESOLVED, That Chapter 4 of The Bylaws, Section 2, have an amending paragraph to read:

"Each associated medical society listed below will be entitled to one delegate and one alternate delegate in the House of Delegates. Both the delegate and alternate delegate must be a member of the OSMA and must be accepted by the Committee on Credentials. Each delegate will have full voting rights, and each organization must submit the name of the delegate and alternate delegate to the OSMA headquarters at least thirty days prior to the first day of the meeting of the House of Delegates."

FISCAL NOTE: \$1000 per year

Any member wishing a complete set of the resolutions to be considered during Annual Meeting should contact the OSMA Department of Continuing Medical Education.

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CONTINUING EDUCATION PROGRAMS

UPDATE ON GERIATRIC MEDICINE-DEPRESSION-PAIN-DRUGS: June 11; Sheraton Downtown Dayton; sponsor: Wright State University School of Medicine; 7 credit hours; fee: \$65, \$50 (Wright State faculty); contact: Arlene Polster, Wright State University, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

FAMILY MEDICINE REVIEW: June 16-20; Hilton Inn, Olentangy River Road, Columbus; sponsor: Ohio Academy of Family Physicians; 40 credit hours; fee: \$250, \$100 Family Practice residents; contact: Mrs. Florence I. Landis, OAFP, 4075 North High St., Columbus 43214, phone: 614/267-7867.

CURRENT CONCEPTS IN SURGICAL PATHOLOGY II: June 5-6, Stouffer's Inn On The Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150, \$75 (physicians-in-training); contact: Director of CME, Cleveland Clinic Educational Foundation; 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

DIAGNOSIS AND REMEDIATION OF CENTRAL AUDITORY DYSFUNCTION IN CHILDREN: May 28-30; Stouffer's Inn, Cincinnati; sponsor: University of Cincinnati Medical Center; 16 credit hours; fee: \$150, \$40 students; contact: Dorothy H. Air, Ph.D., University of Cincinnati Medical Center, #528, Cincinnati 45267, phone: 513/872-4241.

FACING FACES OF ALL AGES: April 26-28; Atwood Lake Lodge Resort, Dellroy; sponsor: Ohio Academy of Family Physicians; 10 credit hours; fee: \$50 AAFP members, \$75 nonmembers; contact: Mrs. Florence I. Landis, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

Scientific Meeting Held

The American College of Nuclear Medicine will hold its 9th annual scientific meeting May 9-11 at the Hyatt Regency Hotel, Montreal, Canada. Subject: Radiation and Public Health: The Myth of Radiation—An Attempt at Clarification. Application being made for Category I credits. Fee: \$95. For details contact: **J. R. MAXFIELD, M.D.**, ACNM Secretary, PO Box 19412, Medical Center Station, Dallas, Texas 75219.

Shall We Restructure The AMA?

BY OSCAR W. CLARKE, M.D.

Shall we restructure the AMA?

This certainly is not a new nor startling question. The Council on Long Range Planning and Development (CLRPD) of the American Medical Association has been considering this possibility since early 1974. During the AMA interim meeting in November, 1975, the Council rendered a report entitled, "The Organizational Structure of the AMA," which dealt with reorganization. It raised some serious and unresolvable philosophical differences concerning the reorganization of the components which comprise the federacy of the AMA. Disagreement in regard to the report developed among some members of the CLRPD and as a result, a minority report was presented by Richard L. Meiling, M.D., Ohio's delegate to the AMA and a member of the Long-Range Planning Council.

At the 1979 AMA Annual Meeting, the Council on Long-Range Planning presented Report B, a follow-up of the original report. This report was based on an intensive study by the CLRPD of the AMA's organizational structure, with particular reference to membership and the need for unity within the profession and among medical organizations.

The CLRPD identified membership as the crucial factor in the decision of restructure to reorganize. Over the past decade, membership in the AMA has not kept pace with the overall growth in physician numbers. Yet, during this same decade, AMA has received an increasing share of its income from membership dues. In 1978, membership dues represented more than 62% of AMA income.

Because of the inflationary environment today, the AMA needs an additional \$5 million per year just to maintain its current programs and activities. That \$5 million represents an additional 20,000 full dues-paying members. In spite of the fact that the AMA is generating revenue from alternate sources, it still is dependent on increased membership dues income for the majority of its support. Between 1972 and 1978, membership in state medical societies increased by 12%, while AMA membership declined by 7.1%. With the exception of the five unified membership states, not one state increased AMA membership by an amount greater than or equal to its increase in the state members and only 22 increased AMA membership at all during that period.

With a decreasing share of the physician population footing the bill it became apparent that the AMA would not be able to continue providing its excellent and much needed services without some restructuring.

In a recent interview, AMA executive vice-president James H. Sammons, M.D., said our profession is entering a new area of challenge. He predicted there will be a new constituency, and pointed out the fact that almost two out of three physicians are either hospital based, salaried, or in group practice. This is a far cry from the old days when AMA basically represented the traditional fee-for-service solo practitioner. He predicts it will be necessary to develop closer ties with the medical specialties, hospitals, medical schools, and all the new organizations such as PSRO's, HMO's and HSA's. He also sees the necessity to deal with the increasing numbers of limited-licensed practitioners who are demanding, and winning, a share of the medical marketplace. Dr. Sammons believes that as a medical Federation truly worthy of the name we will have to expand the Federation from its legal definition and embrace the hospitals, medical schools, specialties, and others.

Currently, AMA membership includes physicians and medical students. The Council is studying various alternatives, one of which is the possibility of offering "institutional memberships" to groups such as hospital medical staffs, HMOs, institutions of physicians, allied health personnel, allied health institutions, and other health-related organizations.

The CLRPD felt that a study of reorganization should include a functional analysis of the activities of a medical organization. The analysis was broken down into two parts. The first asked the question, "What does the physician need from his professional organization?" Eight such needs were identified: (1) *Training*, consisting of continuing medical education involving both registration and accreditation, (2) scientific guidance, (3) ethical guidance, (4) representation in social, economic, and political negotiations, and public relations areas, (5) as professional liability, (6) insurance and investments, (7) loans, credentials, communications/information, and (8) a sense of belonging. The second part of the functional analysis asks which medical organizations can render assistance for these needs. Seven types of organiza-

Shall We Restructure (continued)

tions were identified: (1) metropolitan county societies, (2) rural county societies, (3) state medical associations, (4) national medical organizations, (5) specialty societies, (6) hospital medical staffs, and (7) medical schools.

In view of such a functional analysis, it comes as no surprise that the AMA is the only one of the seven that has some role in every single arena. Therefore, if one of the seven types of organizations is to perform an umbrella role the AMA is not only the clear choice but the only choice.

The umbrella organization would be expected to provide leadership in these major areas. First it should provide direction—by virtue of its expertise, and position in our society, the AMA should provide policy direction and establish acceptable standards of behavior. Second, it should coordinate. The AMA often performs a role of coordinating the various interests of different and often diverse elements. Third, it should be representative and provide a public forum on behalf of the groups under its umbrella.

With these facts in mind, the CLRPD considered several alternative approaches to its reorganization study. The first being to maintain "the status quo." It was the feeling of the Council that many of the membership problems which have developed relate to the present Federation structure. The second was the "pure option," or "organization of organizations" concept. Under this concept, an entire state medical society would join the AMA as an organization, rather than as individual physician members. An offshoot of this concept was "total independent approach," by which there would be no organizational links at all between the various medical organizations. Each would recruit its own members and be in competition with each other. The third option, entitled "The Chapter Option," is the traditional chapter configuration in which the state and county societies would become state and local chapters of the AMA. This differs from the organization of organizations approach in that the state society would become an actual component of the AMA, not just an organizational member. It is not my intention to give the advantages and disadvantages of each option. This was done in "report B" ("AMA Organizational Structure") of the Council on Long Range Planning and Development which was distributed during the AMA's 1979 annual meeting. I would strongly suggest that this report be studied in detail.

The fourth option, entitled "The Mixed Option," represents the middle ground approach and ranges from the pure organization of organizations to the pure independent option.

After studying the advantages and disadvantages of each option, the CLRPD offered three recommendations: (1) that the AMA become the umbrella organization for all of medicine, (2) that as a means of alleviating the immediate membership problem as quickly as possible, the

bylaws be changed to allow AMA to recruit and accept members directly, (3) that the concept of the AMA as an organization of American Medical Organizations be endorsed as a planning objective and that the CLRPD, in consultation with the constituent and component medical associations, continue to develop this concept.

I have pointed out earlier that Dr. Richard L. Meiling presented a minority report to the CLRPD in November, 1975. In his report, Dr. Meiling differed with the CLRPD in six major sections, the strongest being in the change of the concept of "The Federacy of the AMA." Dr. Meiling stated he felt the AMA was, and would continue to be, only as strong as the federacy of state and territorial societies, with the latter being only as effective as the local societies. In addition, he recommended that: (1) there be no reduction in proportionate representation in eleven of the state societies as proposed in the 1975 report; (2) each of 32 medical specialty societies have a delegate in the AMA House of Delegates; (3) there be no change in the medical student business session; (4) the AMA House of Delegates remain a medical professional organization and that student and house staff group representation be limited to the medical student business section and the intern and resident business section; (5) no position on any of the proposed eight AMA councils be slotted for any group.

A copy of the entire minority report is available from the OSMA and should be read along with Report B of the CLRPD.

As Dr. Sammons stated in his interview, "The decade ahead are years of opportunity for medicine. However, the coming decade may well be medicine's last opportunity to direct the changes that threaten us. The Associations' traditional Federation structure—county, state, and AMA—needs considerable change and strengthening if it is to master the challenges of the future."

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G. B. ACKERMAN, M.D., retired December 31, after more than 30 years of practicing family medicine in Wellston, was honored by a resolution passed by the Ohio Senate. Dr. Ackerman was cited for his contributions to the health and welfare of citizens of the Wellston area.

A. R. BASINGER, M.D., Canton, was honored with a retirement luncheon by the administration, staff, and residents at St. Luke Lutheran Home, where he was staff physician for 14 years.

JOSEPH L. BITZAN, M.D., Independence, was elected president of the medical staff of St. Alexis Hospital.

CRAIG G. BURKHART, M.D., Toledo, was named Diplomate of the American Board of Dermatology.

JOHN J. CRANLEY, M.D., Cincinnati, was named winner of the Hull Award for best scientific exhibit at the AMA Winter Scientific Meeting in San Antonio.

Studies of six noninvasive techniques for the evaluation of carotid cerebrovascular disease were presented. Results of the Good Samaritan vascular laboratory's use of these techniques was compared with bilateral carotid angiography.

EVELYN L. COVER, D.O., Port Clinton, was named vice-president, and **ANTHONY RUPPERSBERG, M.D.**, Columbus, remains the secretary of the Ohio State Medical Board.

The Ross County Medical Society held a "roast" at the Chillicothe Country Club in honor of **WILLIAM M. GARRETT, M.D.**, who is retiring after 43 years in medical practice.

A physician in Chillicothe 26 years, Dr. Garrett also practiced medicine in Frankfort, beginning in 1936. He was a major in the U.S. Army Air Corps, and before practicing medicine was a school teacher and coach at West Jefferson High School 1929-1930.

LEONARD M. GAYDOS, M.D., Tiffin, was elected president of Mercy Hospital's medical staff. **JOHN VELA, M.D.**, was elected vice-president, and **DAVID BERCKMUELLER, M.D.**, secretary.

ARMIN GREEN, M.D., Cleveland, president of the Lake County Medical Society, was named medical director for Cancer Family Services, a Lake County agency dedicated to helping families of cancer patients.

JERRY L. HAMMON, M.D., Assistant Clinical Professor (Family Practice) and Associate Chief of Staff for Education at the Dayton Veterans Administration Medical Center, was named Assistant Dean for Veterans Affairs in the School of Medicine. Dr. Hammon is current chairman of the OSMA committee on scientific work and serves on the Ohio delegation to the AMA House of Delegates.

MICHAEL KLEIN, M.D., Shaker Heights, was elected president of the medical staff and chairman of the medical council at Hillcrest Hospital.

Other new officers include **JAMES POSCH, M.D.**, president-elect of the medical staff and chairman-elect of the medical council; **THOMAS HUNTER, M.D.**, secretary; and **CHARLES CASSADY, M.D.**, treasurer.

MARVIN KOPPLESON, M.D., Willoughby, director of coronary care division at Euclid General Hospital, was elected delegate-at-large to the medical staff executive committee for 1980.

WARREN H. LEIMBACH, M.D., Columbus, was elected president of the Grant Hospital medical staff and chairman of the Executive Committee. **JOHN BURNS, M.D.**, Columbus, was elected president-elect, and **JAMES WEBB, M.D.**, Columbus, secretary-treasurer.

CARL A. LINCKE, M.D., Steubenville, was honored at the Aultman Hospital annual meeting for 35 years' service to the hospital and his community.

JOSEPH J. MACEDONIA, M.D., Steubenville, was elected president of the St. John Medical Center medical-dental staff.

W. HUNTER VAUGHAN, M.D., is president-elect, and **NICK L. TEREZIS, M.D.**, secretary-treasurer.

WILLIAM T. MARTIN, M.D., Massillon, succeeds **EDWARD A. HILL, M.D.**, as president of the Massillon Community Hospital medical staff. Other staff officers include **NESTOR V. BANEZ, M.D.**, vice-president, and **JOHN A. FRENZ, M.D.**, secretary-treasurer.

ROBERT T. MCKINLAY, M.D., Marion, was elected president of the ophthalmology staff in the department of surgery at Children's Hospital, Columbus, Ohio.

BRUCE P. MEYER, M.D., Columbus, was elected president of the Children's Hospital medical staff. **THOMAS R. FRYE, M.D.**, was elected vice-president, and **JUAN F. SOTOS, M.D.**, secretary-treasurer.

Effective January 1, 1980, **STANLEY W. OLSON, M.D.**, Rootstown, received the title of Provost and Professor of Medicine Emeritus, by action of the Board of Trustees of Northeastern Ohio Universities College of Medicine.

JAMES PHILLIPS, M.D., physician-in-chief of the Kaiser-Permanente Medical Center in Parma, is featured in the February edition of *Ebony* Magazine. Dr. Phillips is profiled in a section entitled "Speaking of People," which deals with outstanding achievements of black Americans.

JOHN J. PICKEN, M.D., Columbus, was elected president of the Ohio Thoracic Society.

EMMANUEL R. RIFF, M.D., Shaker Heights, was elected president of the medical staff of Marymount Hospital. Other officers include: **GORDON N. FARNER, M.D.**, president-elect; **VIRGILIO A. AVENDANO, M.D.**, secretary; and **NELLIE K. JUSKENAS, M.D.**, treasurer.

WILLIAM E. SOVIK, M.D., Youngstown, was elected president of St. Elizabeth Hospital Medical Center.

New officers of the Ohio Valley Hospital medical staff are: **NICK L. TEREZIS, M.D.**, president; **OTILIA J. ASUNCION, M.D.**, secretary; and **RONALD C. AGRESTA, M.D.**, president-elect.

SAM TETALMAN, M.D., received the Suburban Community Hospital's Physician of the Year Award.

An orthopedic surgery fellowship was established in the name of **JUDSON WILSON, M.D.**, at Riverside Hospital. The Jud Wilson Orthopedic Surgery Fellowship initially will be used to train a resident physician in hand surgery. Later, Fellows will train in other aspects of orthopedic surgery.

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OBITUARIES

GARRET J. BOONE, M.D., Hamilton; University of Cincinnati College of Medicine, 1938; age 77; died February 1; member OSMA and AMA.

JOHN B. CAMPBELL, M.D., Cincinnati; University of Pennsylvania School of Medicine, 1942; age 64; died February 1; member OSMA and AMA.

JOHN C. DRAKE, M.D., Mt. Vernon; Case Western University School of Medicine, 1930; age 77; died January 24; member OSMA and AMA.

EDWARD M. FEIMAN, M.D., Canton; Ohio State University College of Medicine, 1918; age 90; died February 26; member OSMA and AMA.

DONALD S. HALL, M.D., Warren; Northwestern University Medical School, 1943; age 50; died January 27; member OSMA and AMA.

DONALD L. HAMON, M.D., Akron; Indiana University School of Medicine, 1973; age 33; died January 9; member OSMA and AMA.

MAX HENRY KENT, M.D., Gaithersburg, Maryland; Medizinische Fakultät der Universität, Basel, Switzerland, 1930; age 81; died December, 1979; member OSMA and AMA.

PHILLIP T. KNIES, M.D., Columbus; Ohio State University College of Medicine, 1931; age 72; died January 28; member OSMA and AMA.

JAMES M. MULLANEY, M.D., Dayton; University of Michigan Medical School, Ann Arbor, Michigan, 1957; died July 31, 1979; member OSMA and AMA.

HOWARD SCHWINDT, M.D., West Lafayette; Ohio State University College of Medicine, 1932; age 79; died January 21; member OSMA.

WILLIAM SLAGLE, M.D., Dayton; Jefferson Medical College of Thomas Jefferson, 1924; age 78; died August, 1978; member OSMA and AMA.

PAUL R. STAUFFER, M.D., Mesa, Arizona; Ohio State University College of Medicine, 1943; age 61; died February 7; member OSMA and AMA.

ROBERT F. SWANSON, M.D., Fairborn; Northwestern University Medical School, 1943; age 66; died January 22; member OSMA and AMA.

JEAN WOZENCRAFT, M.D., Cincinnati; University of Cincinnati College of Medicine, 1939; age 71; died January 28; member OSMA and AMA.



NEW MEMBERS

ALLEN (Lima unless noted)

Ashwin V. Amin
Shama A. Amin
Anthony J. DeNisco
Frederick Hershey
James F. Rosbolt

ASHLAND

Emmanuel C. Sudhakaran,
Loudonville

ATHENS (Athens unless noted)

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Eugene F. Landers
Andrew W. McDonald

BUTLER (Hamilton unless noted)

Florenda Alquizola
Rodger Brown
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Robert Huber, Carrollton

CRAWFORD (Galion unless noted)

Dale C. Angerman
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David M. Burkons
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F. D. Stockwell

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Martin Fernandes
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Robert L. MacDougall
Elmer J. Perse, Cleveland
Sanford Timen, Mentor
Faissal Zahrawi, Mayfield Village

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F. N. Vargas, Rittman

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MUSKINGUM

Jerry W. Moore, Zanesville

ROSS

Stuart Oppenheimer, Chillicothe

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Gary W. Meade, Fremont

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Melvin C. Chen, Alliance
Thomas E. Dittmer, Canton
Rajnikant Kothari, Massillon
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Elizabeth Specht

WASHINGTON

David C. Ashcraft, Marietta

WAYNE (Wooster unless noted)

Michael Buechler
Allan Shippel



STATE

Senate Passes State Board Bill

The Senate has passed Senate Bill 368, which proposes to strengthen the investigative and enforcement powers of the Ohio State Medical Board. The vote on the measure, which is sponsored by Senator Marcus Roberto (D-Ravenna), was unanimous.

As passed by the Senate, the bill contains several provisions strongly supported by OSMA. An amendment adopted in committee should relieve the necessity of physicians mailing their Continuing Medical Education logs to the board for license renewals. Instead, the bill states that the physician must simply "certify" to the board that he or she has completed the necessary CME hours. This certification, which is comparable to the certification which an individual makes when filing tax forms with the IRS, should eliminate a great deal of red tape for physicians and the board. If the bill is enacted, the board will spot check physicians randomly for verification of CME hours. Therefore, physicians would still have to retain CME records.

As introduced, SB 368 contained a provision which would have required physicians to report to the board (1) any adverse judgment in a malpractice suit, whether or not an appeal was pending, and (2) any malpractice settlement exceeding \$1,000. The malpractice data on individual physicians was to be utilized by the board as a basis for investigation and possible hearings before the board. Presumably, the board was to call in any physician on whom a pattern of malpractice filings developed. This provision was strongly opposed by the OSMA and was deleted by committee.

Under the bill as passed by the Senate, for each MD member vacancy on the board the OSMA is called upon to submit to the Governor a list of five (5) nominees with recognized qualifications for board membership. The Governor would be required to consider these nominees in making his appointment.

The existing triennial registration program is replaced with a biennial program, beginning in 1983. Registration (renewal) fees, which were initially set by the bill as introduced at \$100 a year, would be \$100 biennially. All fees paid to the board would be deposited into a "special account" within the state treasury. All funds in the special account

would be earmarked for use by the board and could not be used for other purposes.

The bill adds an additional consumer member to the board and standardizes the length of term for board members to five (5) years. Currently, MD and podiatrist members serve seven (7) year terms, while DO and consumer members serve four (4) year terms.

With the increased budget the board would place additional investigators throughout the state. The bill grants to the board the authority to subpoena during the course of an investigation. In addition, the board is authorized in emergency situations to take disciplinary action against a practitioner without a hearing, if the health of the public is endangered and as long as a hearing is held within fifteen (15) days. Several provisions in the bill should streamline the process of appeals of board actions.

SB 368 now goes to the House, which will consider the measure in June.

"Living Will" Legislation Proposed

Senator Ken Cox (D-Barberton) has introduced legislation which provides a statutory form for "living wills" in Ohio. The bill would protect physicians, as well as hospital personnel acting on orders of the physician, from civil or criminal liability when he or she withholds or withdraws life-prolonging measures in accordance with a terminal patient's living will.

The bill, SB 400, has been referred to the State Judiciary Committee.

No Action on Medicare Patient "Discrimination" Bill

Twice the Senate Commerce and Labor Committee has placed on its agenda SB 369, which would prohibit physician "discrimination" against Medicare patients, and twice the bill has not been heard. On the day of the first scheduled hearing the bill was pulled from the agenda without explanation. At the second scheduled hearing the sponsor of the bill, Senator Charles Butts (D-Cleveland), failed to appear for sponsor's testimony.

The bill would prohibit a physician from (1) asking a patient if he/she is eligible for Medicare benefits; (2) refusing to accept a patient because

he/she is eligible for Medicare benefits; (3) charging a Medicare patient a fee in excess of the rate determined by the Medicare carrier or the Health Care Financing Administration to be equitable.

The OSMA strongly opposes SB 359.

Overwhelming Opposition Stalls ONA Bill

Hundreds of nurses from across the state crowded into the State House to voice opposition to House Bill 1029, which proposes revisions of the Nurse Practice Act. HB 1029, sponsored by Representative Ed Orlett (D-Dayton), was drafted by the Ohio Nurses Association to change the definition of the practice of nursing, to delete the utilization of interim nursing permits, and to increase the authority of the State Board of Nursing.

The nurses who oppose HB 1029 claim the bill is a first step in an ONA effort to phase out all categories of nursing other than RNs. The massive opposition has delayed further action on the bill.

The OSMA opposes the bill because of the proposed definition of the practice of nursing in the bill, which contains no clear prohibition against acts of medical diagnosis or prescription of medical, therapeutic, or corrective medical measures.

FEDERAL

Regulation of Hospital-Based Doctor Reimbursement

Regulations governing Medicare reimbursement of hospital-based physicians will be uniformly enforced as of July 1, 1980, according to a notice published in the **Federal Register** by HCFA. These regulations, on the books since 1966, specify that payment should be made on a "reasonable charge" basis only if the services rendered require performance by a physician in person or if the services contribute to the diagnosis or treatment of the patient. All other services performed by a hospital-based doctor should be reimbursed on a "reasonable cost" basis, according to the regulations.

HCFA claims that in recent years, particularly in relation to clinical laboratory services, some hospital-based physicians have been receiving reimbursement on the basis of charges for services that are supervisory in nature.

The OSMA opposes this new implementation of 14-year-old regulations and has requested that the Secretary delay or defer the "uniform application" of the regulations.

FTC Authorization Continued

The Federal Trade Commission is still with us. Last month Congress approved still another "continuing resolution" for funding the agency, which has not operated under a budgetary appropriation for 2 years. OSMA members should thank Congressman Thomas Luken (D-Cincinnati) and Congressman Samuel Devine (R-Columbus) for their continued support of a House-approved provision empowering either the House or the Senate to veto any FTC rule within 60 days after promulgation. The Senate alternative is weaker, requiring vetoes in both the House and the Senate, as well as concurrence by the President. Authority to veto rules would give the Congress some control over the agency's harassment of the profession.

The House Judiciary Subcommittee on Administrative Practices has sent its regulatory reform bill, HR 3263, to the full Judiciary Committee. HR 3263 is one of the few regulatory reform bills moving in the House. Congressman Thomas Kindness (R-Hamilton) offered an amendment to the bill that would have given either the House or the Senate the authority to veto "major" agency rules. Although the Kindness amendment was defeated, the bill makes some headway against regulatory red tape. For example, the bill requires government agencies to prepare regulatory analyses before rules are issued.

The OSMA continues to support a number of legislative proposals, such as HR 3263, that would reduce the ever-increasing role of the government regulators on the physician and his or her practice.

Clinical Lab Personnel Standards Still Alive

In October, 1979, the Department of Health, Education, and Welfare issued proposed personnel standards for hospital clinical laboratories. This proposal generated thousands of comments nationwide, including over a hundred comments from physicians, labs, and hospitals throughout Ohio. Rather than responding to the comments received after their **Federal Register** announcement, the Center for Disease Control (CDC) has instead solicited the comments of various organizations as to their specific recommendations for such standards. The results of this outreach will then be used as a basis for participation at an open meeting on the subject to be held by CDC in Atlanta in early June.

The OSMA and the AMA objected to the use of personnel standards for hospital clinical labs and noted a lack of substantive data indicating major deficiencies in hospital lab performance.

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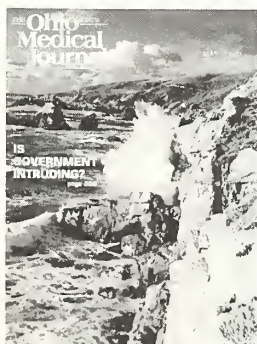
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OUR COVER

Our cover photograph was taken by Carol Mullinax, Assistant Director of Communications of the Ohio State Medical Association, with a Canon FTB using Kodachrome II film. The photo was taken November, 1978 at Big Sur, California.



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THE AUXILIARY AND THE LEGISLATORS

Karen S. Edwards

Each year, members of the OSMA Auxiliary spend a "Day at the Legislature" here in Columbus. They attend hearings of bills being discussed, and meet with many of the legislators involved in those bills. The Journal provides a pictorial account.

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IS GOVERNMENT INTRUDING?

Rebecca J. Doll

Many feel that the Federal Government and its agencies have become too intrusive in today's society. Is the Government intruding where it has no business intruding, or is it, in fact, only meeting public demand for services? Ohio Supreme Court Chief Justice Frank D. Celebrezze takes a look at the question in this month's OSMA interview.

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OSMA OFFICERS

President

THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631

President-Elect

ROBERT G. THOMAS, M.D.
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Elyria 44035

Past President

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7911 Detroit Avenue
Cleveland 44102

Secretary-Treasurer

DAVID A. BARR, M.D.
825 West Market Street
Lima 45805

EDITORIAL STAFF

Consulting Medical Editor

Richard L. Meiling, M.D.

Managing Editor and Business Manager

Hart F. Page, C.A.E.

Director, Department of Communications

Rebecca J. Doll

Assistant Director

Carol W. Mullinax

Managing Editor

Karen S. Edwards

Editorial Assistant

Carol J. Wiley

Production Assistant

Corene W. Davis

Contributing Editors

Richard A. Ayish, Eric L. Burkland, Jerry J. Campbell, Robert D. Clinger, Gail E. Dodson, Rebecca J. Doll, Herbert E. Gillen, Robert E. Holcomb, D. Brent Mulgrew, J.D., Carol W. Mullinax, Jennifer M. O'Brien, David W. Pennington, David C. Torrens, and Katherine E. Wisse.

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Karl S. Messerly
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16 Bruce Park Avenue
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Telephone: 203/661-9702

Regional

The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

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LETTERS TO THE EDITOR

To the Editor:

It is long past time to give Iran some unpleasant choices. The Congress should enact a law fining Iran \$100 million per day that the hostages continue to be held. This can easily be collected from the 8 billions of frozen funds now held in the United States. The first use of this money should be to compensate the hostages with \$2 million apiece for their ordeal. The rest should be used for scholarships in United States colleges for talented foreign students. Such use of the money would reduce any possible foreign criticism of our actions.

We apparently fear Iranian annoyance at anything we might do. They will continue to harass the hostages until it is in Iran's best interest not to do so. When Iran is losing \$1 million every 15 minutes, freeing the hostages will suddenly become more urgent to them.

/s/William H. Havener, M.D.

The Older Woman

Women in the 65 and older age group are the fastest growing segment of the United States population, with 13.9 million older women (versus 9.5 million older men) in 1977 expected to increase to 33.4 million women (versus 22.4 million men) by the year 2035. Yet the needs and achievements of the older women have been largely overlooked.

A report on a workshop on *The Older Woman: Continuities and Discontinuities* was published recently. The workshop was sponsored jointly by the National Institute on Aging and the National Institute of Mental Health.

The report explores a wide range of issues including: physical and mental health of older women, delivery of health services, the family and social systems of older women, and labor force participation and retirement. Other areas examined include: diversities among older women, and key demographic issues concerning women over 70. To obtain single copies of *The Older Woman: Continuities and Discontinuities*, write to: Expand Associates, Inc., Attention: Jim Giglio, 8630 Fenton Street, Suite 508, Silver Spring, Maryland 20910.

Motivating Your Employees To Solve Problems

By Jack Valancy

"A leader is best when people hardly know that he exists. Less good when they praise him and obey him. Worse when they fear and despise him. But a good leader, when his aim is met and his dreams fulfilled, they will say: 'We did this ourselves.'"

Lao-tse

"If only my employees were motivated," begins the lament of the physician, "then my problems would be over." Motivation—that will-o'-the-wisp that can transform a lackadaisical staff into an effective, hard-working team. Motivation—that magic substance not available with or without a prescription.

What is motivation? The dictionary defines a "motive" as "some inner drive, impulse, intention, etc., that causes a person to act in a certain way." The object of employee motivation is to awaken and encourage the inner forces that cause your employees to perform well in your office.

Why are some physicians so successful when it comes to having a motivated staff? High wages and generous benefits do not insure motivation, and it is not entirely due to skill and luck in selecting employees.

You, the physician, have the greatest influence on your employees. You have the power to increase or decrease their level of motivation by your attitude and behavior.

Your employees respond to your attitudes, and if you try to keep your feelings to yourself, most people can sense if you hold them in low esteem. It is unlikely that someone who is viewed in this manner will display high motivation.

You may find that you constantly are correcting certain employees. The difference between constructive criticism and fault-finding is point of view. A steady stream of corrections and exhortations promotes employee frustration. Resentment builds on both sides and an adversary relationship develops. People become withdrawn. When they stop talking to each other, the problem-solving process ends. The only problem your employee is motivated to solve is how to keep you off his or her back.

How can you change this failure to communicate? You can start by telling your employees you feel their work is important. How well would your practice run if you had to do everything yourself?

Be generous with your praise of a job well done. Everyone likes to have their efforts recognized. Your appreciation will encourage your employees to reach new heights. Be sincere; most people can detect quickly false praise.

When a problem arises, control your urge to place the blame on someone. First, it may not be entirely that person's fault. Second, just because you pinned it on someone does not mean you solved the problem.

Many practices use staff meetings as a forum for presenting and solving problems. Meetings may be held on a regular basis or scheduled as needed to address a specific issue.

Productive meetings do not just happen, they are planned. Planning begins with an agenda. Let everyone contribute to it. A written agenda distributed before the meeting informs the participants of what will be covered. They can think about the problems and prepare for the work to be done.

People are motivated to solve a problem when they accept it as a situation to be improved. Getting your staff to accept a problem is easy once you answer the unspoken question: *What's in it for me.*

You may think your employees will respond to money. Money may get results—on one problem. However, you will have to provide more money to get the next problem solved, and more money for the problem after that. Money is an expensive way to solve problems.

People feel good when they solve a challenging problem. You make them feel better when you recognize their achievement. If the work is interesting, they may take responsibility for solving the next problem.

Discuss the situation with your staff. Try to determine how it affects your practice. Why is it a problem? Does it compromise the quality of patient care, upset the smooth operation of the office, or cause the practice to

continued on page 270

Motivating Employees (continued)

lose money?

Encourage each staff member to participate in the discussion by soliciting views and listening attentively. Refrain from being critical and never force someone to speak. Reluctance may be due to fear that you will disagree or argue.

Find out as much as you can regarding the problem. Take the problem apart. How often does it happen? Under what circumstances? How big is the problem? Examine specific instances. Your staff may require some time to uncover all the facts. It may be necessary to have someone research the problem and report back to the group at the next meeting.

When all the facts are in, discuss your current understanding of the situation together. Determine if everyone shares a similar concept of the problem. You may find it helpful to write down the group's definition of the problem.

Now it is time to start generating ideas for solutions. Do not judge the quality of ideas at this point; constructive criticism comes later. It is important to think of as many ideas as possible. Formulate new ideas by modifying ideas already given; don't hold back.

After about five minutes you should have several dozen ideas from which to choose. Although most of them may be impractical, a few will be worth exploring. A by-product of the idea generation process is that employees who usually are quiet at staff meetings tend to get involved with the activity and participate. Even if their ideas are not good, be supportive of their participation.

Once the group has selected a feasible solution, give enough freedom to develop and implement it. Your involvement should be limited. Resist any urges you may have to roll up your sleeves and do the job yourself. Remember, the point is to motivate *your employees* to solve the problem.

You may wish to review and approve the changes before they are implemented. You probably will detect some shortcomings with the details presented by your staff. This requires a delicate touch. You want to avoid discouraging your employees.

One method for dealing with imperfections is to ask questions. Questions are less threatening than statements. They lead people through your reasoning process without raising their defenses. Notice the difference between, your method will cause patients to back up at the reception desk, versus, what effect will the new method have on patient flow at the reception desk.

The first comment indicates that you already have reached a conclusion. It is easier for your employee to respond to the question.

You have the power to veto a proposed solution if you are certain it will have negative results. You can kill an idea (and employee initiative) just as effectively by

nit-picking. Respect the differences between major and minor flaws.

After the solution is implemented, find out how it is working. Are things turning out as expected? Are there any difficulties? Are additional resources required? Provide what is needed and do not let a potentially good solution wither and die.

Your employees' involvement with a problem increases their commitment to solving it. It becomes *their* problem. They have a stake in making sure their solution works.

Do not be frustrated if it takes a little time for your employees to become involved. Be patient and recognize good work and participation with praise. Someone is sure to become fascinated with a problem. Nurture this desire carefully. Take care not to cut down initiative with criticism.

Allow your employees a little room to work on the problem. Their first endeavor may not be perfect, but their next attempts will be better. They will be eager for the opportunity to improve. They will be acting in response to "some inner drive, impulse, intention, etc." In short, your employees will be motivated to solve problems.

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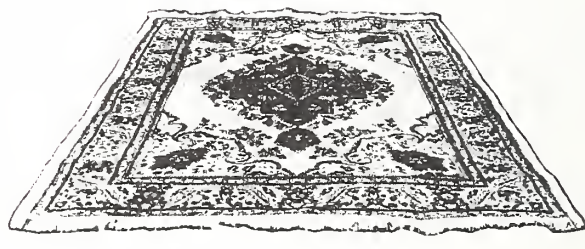
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*Editor's Note*

With this issue, the Journal introduces a new column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

Technician-Physicians— How Far Will They Evolve?

By Sylvan L. Weinberg, M.D.



Sylvan L. Weinberg, M.D.

The following article is an excerpt from the inaugural address of Sylvan L. Weinberg, M.D., newly installed president of the Montgomery County Medical Society. Dr. Weinberg provides an excellent discussion of the future of medicine as it pertains to technology and communications with patients.

Since World War II, there has been an unprecedented explosion of knowledge and technology. These advances have altered medicine so that many of the things we do today were not even thought of 25 or 35 years ago. Before World War II the skillful doctor, working almost alone, could handle most of the problems. The arrival of the doctor and his little black bag provided a justified sense of calm and confidence among patients. This is no longer true. Monitors, intensive and coronary care units, open heart surgery, endoscopy for every orifice, CAT scanners, and radio-dispatched telemetry rescue units have placed medicine far beyond the scope of the individual doctor working alone.

Nurses have assumed responsibilities and performed procedures which in the past were the province of the physician. Physician assistants entered the scene. The health care team suddenly appeared.

To all these changes was added a universal challenge to all constituted authority throughout the country. This applied to teachers, professors, lawyers, and government officials. The physician's word was no longer unquestioned.

Consumerism, too, changed the practice of medicine with such phrases as "informed consent," "patients' rights," and "patient education." It became necessary for the physician not only to be competent professionally, but to transfer some of his knowledge and decision-making authority to the patient.

I am not presenting these changes as necessarily un-

Technician-Physician (continued)

favorable. I am only pointing out that they have occurred.

With exploding technology came tremendously increased costs which were beyond the capability of most individuals. This led to government financing, government control, and inevitably, government regulation. Not only did the government enter into many aspects of practice with its guidelines for procedures, dosages of drugs, and criteria for hospitalization and length of stay, but it also financed special new units such as mental health and rehabilitation centers.

In these units particularly, the regulatory process encroached on the prerogatives of practice and required doctor and patient to fit into the guideline mold. Even in the field of medical ethics, agencies such as the Federal Trade Commission challenged the right of societies to set standards of professional education and behavior. Specialty societies created to insure the quality of medical practice and protect the public, found themselves accused by the government of restraint of trade. The professionalism which condemned advertising and self-praise was denounced and physicians were pushed into the advertising arena.

The scientific advances, new technology, team approach, and the vastly sophisticated hospital facilities have produced many spectacular medical and surgical results. Scientific progress has caused subspecialization and super-specialization which gradually has narrowed the physician's range of activity and the breadth of knowledge. This trend inevitably placed a premium on technical skills.

Changing Relationships

Subtly and unwittingly, the physician emphasized his technique while abandoning his art. Because of the requirements of high technology, medical schools preferred scientifically trained students to the more liberally educated person steeped in the humanities and with an appreciation for humane values. The broadly educated physician of the past gave way to the highly trained and skillful physician-technician. This, coupled with the rising tide of consumerism and the problems of malpractice, changed the relationship of patient and physician.

For example, if all the complications possible from a procedure or operation were not explained to the patient, the physician might be held liable.

The result? Before cardiac catheterization, before an operation, before an invasive x-ray procedure, the physician had to recite a litany of possible complications, even including death. The hospital chart somewhat coldly recorded that this was told to the patient. This approach has become necessary because of the changes which I have described, but it has taken from the physician the capacity to judge what the patient should be told, and has taken from the patient the right to be protected by the physician's judgment. The potential ill effect on

the patient from the negative suggestion which occurs with so-called informed consent can be feared but not measured.

Technique vs. Art

The physician, then, is faced with an increasing requirement for more narrow technical skill. He is confronted with a more inquisitive, less trusting public. He is placed on the defensive by an aggressive legal community seeking out the slightest flaw in his behavior. To all this is added a pervasive government which is trying, through regulation and control, to cope with rising costs, inflation, and continuing demands for government-provided universal health care.

I consider it of paramount importance that the physician resist the forces which are making him a technician, however skillful a technician he may be. He must acquire the skills and the technique without becoming a technician. A technician is trained to do a task and to follow guidelines.

A physician is educated to solve problems through exercising his judgment which is based on knowledge, experience, and a sense of responsibility to the patient.

When the physician's desire to perform his procedure or exercise his technique begins to take precedence over solving the patient's problem, he has no chance to retain the professionalism which is the hallmark of his calling.

"... if the physician does not talk and listen to the patient and spend time with him so that he is understood, he is fast becoming a technician, and fast ceasing to be a physician."

I would like to put this as case finding versus problem solving. This applies to all specialties. I do not want to single out any one.

In my own field, the patient with chest pain comes to the doctor to find a solution to his problem. He does not come to have an arteriogram, stress test, or operation.

Regardless of the specialty and the consummate skill which the subspecialties require, if the physician does not talk and listen to the patient and spend time with him so that he is understood, he is fast becoming a technician and fast ceasing to be a physician. He will no longer command the respect and autonomy the profession demands, and which he must have in order to do the best and most effective job in treating his patient.

There have been many benefits from the so-called team approach to medicine. Medicine is too complex, as I have said earlier, for one individual to be able to be all things to every patient.

The pressures of time have led us to develop what might be called physician extenders—nurse educators, nurse clinicians, physician assistants, social workers—all have contributed tremendously to the medical profession. However, if the physician thinks these people can be used to make his work easier, to save time, and to remove certain responsibilities from him, rather than to enable him to serve the patient more effectively, he may face ultimate disappointment. These groups will seek autonomy. There already are efforts among them to become independent practitioners.

Time with Patients

As the physician spends less time with the patient, they spend more. As the physician relinquishes his role as the person who talks, listens, and advises the patient, he will slowly but inevitably relegate himself to the role of the technician which he so much wishes to avoid.

We often give lip service to the physician-patient relationship while, at the same time, do things which depersonalize and destroy it. The abrogation of the physician's classical role, in his haste to perform procedures and to save time, will do more harm to the profession and the patient than all the government guidelines and commissions combined.

Although we as physicians, and society in general, recognize that medicine is becoming more technical and less personal and that the physician-patient relationship is being eroded, it will be difficult to change this trend for two reasons:

First, it is the nature of medical and scientific progress that high technology evolve and superspecialization occur.

Second, while society is quick to criticize the hurried, tersely speaking, superspecialized physician, it continues to reward procedures and high technology far more than time spent with the patient.

This principle was stated very clearly by Dr. David Rogers of the Johnson and Johnson Foundation in the *New England Journal of Medicine*. He said, "Our current financing mechanisms peg personal physician-patient interactions as 'loss leaders' and over-reward the use of tests, procedures, and devices. There are striking financial incentives that coax physicians to go with the techniques as the most economical use of their time.

"Using techniques results in far more income than using one's head and hands for the same time spent."

Perspective for Change

The real impetus for change will come only through the educational process. Medical school curricula must

inculcate in all physicians better knowledge of the many new techniques. They must be taught to place the value of tests and procedures in perspective so there will be a limitation to excessive and wasteful application. If society wants more physician time, it will be necessary to stop over-valuing technical procedures and under-valuing time spent with the patient in diagnosis and treatment.

In essence, this means that the patient's problem must take precedence over the procedure. Our new technology must be used to serve the patient. The patient must not become a vehicle for our new technology.

This is of critical importance if we are to retain the right to treat the patient without the restraint of third-party control and government guidelines and the bureaucratic requirement for consensus which will lead only to the practice of mediocrity.

In the final reckoning, I have no doubt that our high technology and new procedures will survive and improve, as they must for progress to occur. I also have no doubt that the growth of government regulation and control will manage to keep pace with medical progress. I have grave doubt that in the future we will continue to have with us the broadly educated, independent, humane physician.

This is up to us.

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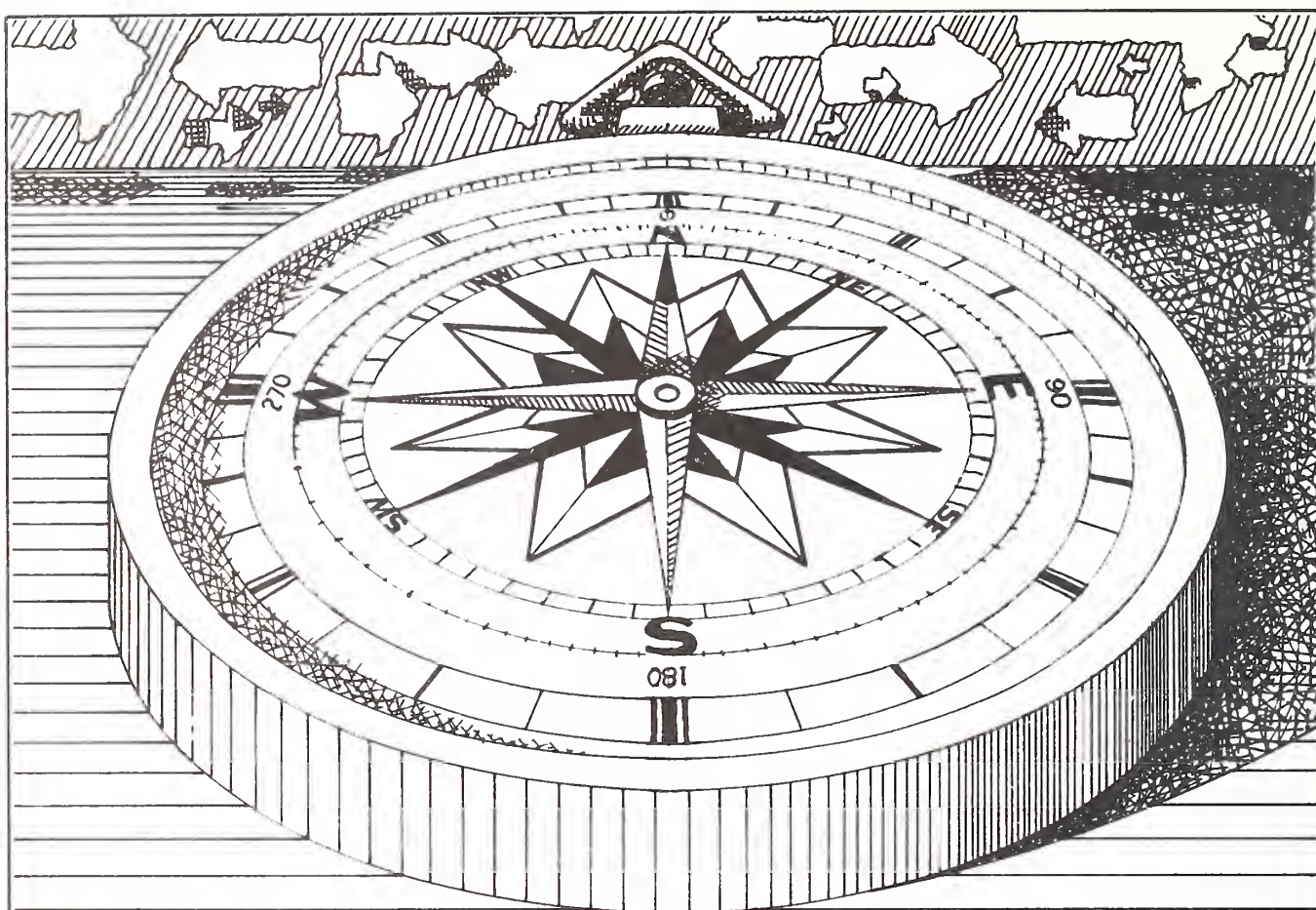
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PROCEEDINGS OF THE COUNCIL

March 1-2, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, March 1, and Sunday, March 2, 1980 at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; Oscar W. Clarke, M.D., Gallipolis; John H. Ackerman, M.D., Columbus; W. J. Lewis, M.D., Dayton; James E. Pohlman, Esq., Columbus.

Those present from the OSMA staff Saturday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Richard A. Ayish, Rebecca J. Doll, David C. Torrens, Carol W. Mullinax, David W. Pennington, Eric Burkland, Karen Edwards.

Those present Sunday were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; C. Douglass Ford, M.D., Toledo; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; W. J. Lewis, M.D., Dayton; James C. McLarnan, M.D., Mt. Vernon; James E. Pohlman, Esq., Columbus.

Those present from the OSMA staff Sunday were: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll.

The minutes of the January 26-27, 1980 meeting of the Council were *approved*.

The Council voted that AMA members be identified at the OSMA Annual Meeting by a special ribbon attached to the member's badge.

Deans' Committee

The Council considered a motion that the structure of the Deans' Committee include the deans of all Ohio's medical schools, and that the committee be an instrument for dealing with problems of mutual concern.

There was a suggestion for periodic joint conferences with the committee.

Final action on the matter was postponed until the next meeting of the Council.

Task Force on Medical Licensure and Enforcement

The Council asked the immediate establishment of a Task Force of OSMA on Medical Licensure and Enforcement to evaluate problems of the Ohio State Medical Board and to make recommendations for appropriate legislation.

Special Reports

The Council voted to present special reports on "legislation" and on "membership" at the annual meeting of the Association in May.

The Council voted to submit to the House of Delegates a resolution to change the name of the Committee on Scientific Work to the Program Committee; Membership and Planning to Membership Committee; and PR & Economics to Communications Committee.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Mrs. Wisse presented membership statistics and the treasurer's report, in the absence of Dr. Barr.

With regard to participation in a pilot project on AMA membership development, the Council voted against OSMA involvement at this time.

In a subsequent action, it asked that the staff further investigate the nature of the pilot study, bring complete details back to the Council for reconsideration, and requested that the county medical society chosen for the pilot study be informed and consulted.

Committee on Auditing and Appropriations

Dr. Williams presented the minutes of the February 22, 1980 meeting of the Committee on Auditing and Appropriations.

A proposal for an incoming "800" telephone line was not recommended by the committee and the Council concurred. Leasing of "800" equipment on a need basis for special projects was *approved*.

The Council *approved* a committee recommendation to introduce in the House of Delegates a resolution to increase OSMA dues by 15% i.e., \$25, to deal with the effects of inflation.

The minutes, as a whole, were *approved*.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

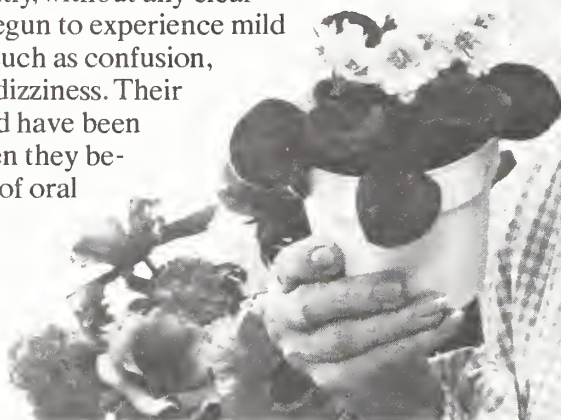
Committee on Education

Mrs. Dodson presented the February 14, 1980 minutes
continued on page 279

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

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Oral Hydergine tablets promote better patient compliance

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Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936



Council Proceedings (continued)

utes of the Committee on Education.

A procedure mechanism for reconsideration and appeal of adverse accreditation decisions concerning continuing medical education programs was discussed and *was approved*.

DEPARTMENT OF GOVERNMENT RELATIONS

The Health Planning update was presented by Mr. Pennington.

The Council *approved* the redesignation of the Ohio Department of Health as the SHPDA (Statewide Health Planning and Development Agency) in Ohio.

The report was accepted.

Committee on Maternal and Neonatal Health

Mr. Gillen presented the minutes of the February 3 meeting of the Committee on Maternal and Neonatal Health.

The Council discussed the committee's report on "Ultrasonography Usage in Pregnancies" and asked that it be received and referred to the Committee on Medical Services Review.

The Council declined to concur in the committee's recommendation for endorsement in principle of the "State Perinatal Guidelines" and the Committee's offer of assistance in their implementation. The guidelines were received and filed.

The Council then voted that the minutes of the committee be filed.

Committee on Government Medical Care Programs

Dr. Kilroy presented the minutes of the February 27, 1980 meeting of the Committee on Government Medical Care Programs.

The Council considered the committee's recommendations with regard to reimbursement of Salaried House Physicians and *approved* them.

The report, as a whole, was accepted for filing.

Membership Committee

Mr. Gillen presented the minutes of the February 13 meeting of the Committee on Membership.

The Council *approved* the Committee's recommendation for medical specialty representation in the OSM House of Delegates and the following resolution *was approved* for submission to the House of Delegates:

MEDICAL SPECIALTY REPRESENTATION IN OSM HOUSE OF DELEGATES

WHEREAS, Many issues concern all medical societies and medical specialties within the family of medicine, and

WHEREAS, Achievement of common goals by medical societies requires close cooperation and coordination; and

WHEREAS, There is currently no official mechanism for input in regard to matters specifically and particularly affecting a medical specialty; THEREFORE, BE IT

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended to provide for Medical Specialty representation in the House of Delegates as follows:

Chapter 4. The House of Delegates

Section 3. *Representation of Medical Specialties:*

A Medical Specialty, defined as a member organization of the American Board of Medical Specialties as listed in the current edition of Directory of Medical Specialties, is eligible to apply for representation in the House of Delegates.

The physicians represented by his specialty:

- (a) Must number at least 50.
- (b) At least 50 per cent of these physicians must be members of the Ohio State Medical Association for the first year of representation; 60 per cent the second year; and 75 per cent the third year and for each year thereafter.

A Medical Specialty seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the applicant specialty qualifies for representation. In the event that more than one application is made for a given specialty, the House of Delegates will determine which group shall be designated.

Each recognized Medical Specialty shall have one delegate and alternate who must be members of the Ohio State Medical Association. Each specialty will certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate, and its membership certification as required by subsection (b) above. A Medical Specialty delegate shall have all rights, privileges and duties as other delegates.

Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates, AND BE IT FURTHER

RESOLVED, That the remaining sections of Chapter 4 be renumbered accordingly beginning with Quorum as Section 4.

DEPARTMENT OF ORGANIZATION SERVICES

Ad Hoc Committee on House of Delegates Policy

Dr. McLarnan presented the report of the Ad Hoc

Council Proceedings (continued)

Committee on House of Delegates Policy.

A motion passed that the Council make no editorial changes in any resolution recommended for retention by the House of Delegates.

Subsequently, the Council voted, upon reconsideration, to recommend that editorial changes be designated in those resolutions recommended for retention while making it clear to the House of Delegates that they are recommendations from the Council for clarification and simplification and are not substantive changes.

The Council voted that a copy of all House of Delegates proceedings from 1929 through 1978 be submitted to each councilor for use in caucuses before and during the Annual Meeting.

The Council voted to recommend to the House that in lieu of retaining Resolution No. 15-76 (OSMA Position on Public Law 93-641), the resolution be reconsidered for updating in 1981.

The Council voted to recommend to the House that Sub. Resolution No. 82-77 (Improved Effectiveness of the Ohio State Medical Board) not be retained.

The Council considered proposed resolutions submitted by the Ad Hoc Committee as follows:

A proposed resolution on "Billing by Physicians for Fees and Reimbursement by Third Parties" was referred to the Committee on Government Medical Care Programs for consideration as a possible emergency resolution.

The Council then *approved* the following resolutions for introduction to the House:

OSMA COUNCIL RESOLUTION

(Establishment of Councilor Districts)

RESOLVED, That Chapter 4, Section 6, of the Bylaws of the Association be amended to provide as follows: The House of Delegates shall establish councilor districts. The districts shall comprise one or more contiguous counties. A district society may be organized in any of the councilor districts to meet at such time or times as such society may fix.

OSMA COUNCIL RESOLUTION

(Confidentiality of Physician-Patient Communications)

RESOLVED, That Ohio physicians should, in the highest and best tradition of the profession and in accordance with the Ohio law affirming the physician-patient privilege, strictly observe and hold inviolate all communications between them and their patients except in those instances where patients expressly waive the privilege or the privilege is waived by operation of law.

OSMA COUNCIL RESOLUTION

(Definition of Death)

RESOLVED, That OSMA petition the Ohio General Assembly to adopt the American Medical Association model uniform law on definition of death.

The Council voted that any resolution removed from the "deletion list" by the House be docketed for consideration the following year.

The Council *approved* the report of the Ad Hoc Committee, as a whole, as amended, with commendation to the committee.

Ad Hoc Committee on

House of Delegates Voting Procedures

Dr. Payne and Mr. Campbell presented the minutes of the February 9, 1980 meeting of the Ad Hoc Committee to Review House of Delegates Voting Procedures, along with a proposed resolution, the text of which is presented below:

OSMA COUNCIL RESOLUTION

Proposed Amendment to the Bylaws to
Define Valid Ballots in Elections

WHEREAS, Delegates and alternate delegates to the American Medical Association have been chosen by a method of voting referred to by Sturgis (OSMA Parliamentary authority) as "Simultaneous election of candidates to several positions of equal rank"; and WHEREAS, Thomas W. Morgan, M.D., President of OSMA, appointed an Ad Hoc Committee to evaluate the OSMA House of Delegates voting procedure; and

WHEREAS, Examination and careful scrutiny by the Ad Hoc Committee of the ballots from the 1979 OSMA House of Delegates Annual Meeting demonstrated significant intent and potential for influencing the results of multiple candidate elections; THEREFORE BE IT

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended by adding at the end of the third and last paragraph the following: "No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee." (For example: If upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for four (4) of the nominees for such positions.)

The Council *approved* the resolution for consideration by the House.

The report of the Ad Hoc Committee was filed.

AMA Report

Dr. Lewis reported to the Council regarding American Medical Association activities, policies and problems having to do with federal government programs and proposals.

He emphasized the shift in emphasis in regulations from the federal government to the state government level.

DEPARTMENT OF HEALTH EDUCATION

Joint Advisory Committee on Sports Medicine

Mr. Clinger presented the January 30 recommendations of the Joint Advisory Committee on Sports Medicine.

The report was accepted for information.

Committee on Health Manpower

Mr. Clinger presented the minutes of the February 20 meeting of the Committee on Health Manpower and they were accepted.

Subcommittee on Impaired Physicians

Mr. Clinger presented the minutes of the February 24, 1980 meeting of the Subcommittee on Impaired Physicians.

The Council supported the Committee's recommendation on involvement in training programs for Board Investigators.

The report, as a whole, was accepted.

Committee on Traffic Safety

Mr. Clinger presented a survey on medical aspects of driver certification from the Committee on Traffic Safety.

The report was accepted for information.

School Bus Driver Qualifications Advisory Committee

Mr. Clinger presented the minutes of the first meeting of the School Bus Driver Qualifications Advisory Committee held February 22, 1980.

The report was accepted for information.

OSMA/ONA Liaison Committee

Mr. Clinger presented the February 27, 1980 minutes of the OSMA/ONA Liaison Committee. The report was accepted for information.

Subcommittee on Education

Mr. Clinger presented the minutes of the February 28, 1980 meeting of the Subcommittee on Education of the Joint Advisory Committee on Sports Medicine.

A suggestion for programs in sports medicine in schools was *approved*.

The report, as a whole, was accepted.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Mr. Mulgrew discussed federal developments, including the McGuire amendments, HR 4000, involving medicare amendments regarding mandatory second opinions.

With regard to State Legislation, Mr. Mulgrew stated that the department has been involved in an average of 13 hearings a week during the three weeks prior to March 1.

Mr. Mulgrew and his staff reviewed 21 proposals which have received the attention of the department during the period since the January meeting of the Council.

Dr. Ford presented the minutes of the Committee on State Legislation.

The following decisions were made by the Council:

H.B. 703 — SALES TAX EXEMPTION FOR MEDICAL ITEMS

H.B. 703 is intended as "umbrella" language for sales tax exemptions for medical items. The bill exempts certain items under prescription from state and local sales taxes, including hearing aids, optical lenses, and oxygen. The bill has been reported out of subcommittee to the full House Ways and Means Committee. *ACTION*: Active Support.

S.B. 253 — AUTOMOBILE CHILD RESTRAINTS

Mandates automobile child restraints — S.B. 253 requires parents to secure their children under four years of age or less than forty pounds in child restraints in their automobiles. The bill passed the Senate and House Transportation Committee but was pulled off the floor and re-referred back to the House Rules Committee. *ACTION*: Support as amended.

H.B. 768 — Requires permits for transportation of certain radioactive materials and requires the EPA Director to maintain a current list of all handlers of radioactive substances. *ACTION*: Active Support.

H.B. 938 — Establishes a state loan program for medical school students. The bill contains a loan forgiveness provision for students who practice in physician shortage areas of Ohio including facilities operated by the Department of Mental Health and Mental Retardation and Department of Corrections. *ACTION*: Support.

With regard to a radiologic health bill draft proposal, the Council requested preintroduction amendments.

The report, as a whole, was accepted.

INSTANT LEASING

1980 Olds Cutlass

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per mo.

1980 Olds Custom Cruiser Wagon

Diesel, loaded. 36 mo. closed end. Price includes sales tax, free laaner..... **\$259⁷⁹**
per mo.

1980 Olds 98 Regency Sedan

Loaded. 36 mo. closed end. Price includes sales tax, free laaner **\$267⁸⁸**
per mo.

1980 Olds Toronado Brougham

Loaded. 36 mo. closed end. Price includes sales tax, free laaner **\$299⁸³**
per mo.

1980 Cutlass Cruiser Wagon

V-6, air, t. glass, auto., PS., PB., cruise control, AM radio. Closed end. 36 mo. Price includes sales tax. Free laaner **\$187⁰¹**
per mo.

1980 Delta 88 Sedan

307 V-8, fully equipped. 36 mo. closed end. Price includes sales tax. Free laaner car **\$203⁶⁰**
per mo.

1980 Mercedes-Benz Sedan

2.4 litre, 4-cyl. diesel. 48 mo. closed end. Price includes sales tax **\$431¹⁶**
per mo.

1980 Mercedes-Benz 450 SEL

4.5 litre, V-8. 48 mo. closed end lease, price includes sales tax. **\$751⁰⁰**
per mo.

1980 Mercedes-Benz 450 SL

4.5 litre, fuel-injected overhead cam V-8. 48 mo. closed end lease, price includes sales tax. **\$828⁰⁰**
per mo.

1980 Sedan DeVille

loaded, 36 mo. closed end lease, price includes sales tax. **\$326⁷⁶**
per mo.

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Council Proceedings (continued)

DEPARTMENT OF COMMUNICATIONS

Committee on Public Relations

The February 29 minutes of the Committee on Public Relations were presented by Ms. Doll.

An advertising program for *Synergy* in weekly newspapers *was approved*.

The Council *approved* the publication of an out-of-state edition of *Synergy*.

The Council endorsed a Burroughs Wellcome project to assist county medical societies in implementing radio and television programs.

The Council *approved* the committee's recommendation for two Media Training Seminars. A suggestion for eliminating the fee for the programs was not approved.

A media and community audience training program on a pilot basis, for in-depth training of six physician spokesmen, *was approved*.

The Council *approved* a pilot project involving a "mini-internship" providing for medical reporters, legislators, etc., to observe the physician as a practitioner.

A joint project of OSMA and Ohio Hospital Association involving a four-page newsletter for hospital patients *was approved*.

The report, as a whole, *was approved*.

FIELD SERVICE DEPARTMENT

Model Bylaws

Mr. Holcomb, in the absence of Dr. Dorner, presented an amended report of the Ad Hoc Committee on Model County Medical Society Bylaws, to recommend the elimination of the "associate membership" category. The Council *approved* the report.

OHIO DIRECTOR OF HEALTH

Dr. John H. Ackerman addressed the Council. He indicated that no funds were appropriated for the Marijuana Research Bill, which has passed the Ohio Legislature.

The epidemic of influenza produced an estimated 100,000 cases, mostly Type "B" Singapore.

He said that there were 110 cases of Reye's syndrome in Ohio, with 86% preceded by an upper respiratory infection. There were three fatalities.

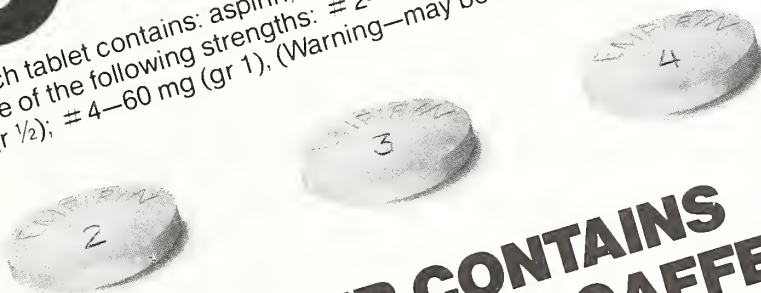
ADJOURNMENT

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

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The Auxiliary and the Legislators

By Karen S. Edwards

They came, they saw, they listened . . . and if they didn't quite conquer, they did, at least, express themselves as constituents with concerns.

Auxiliary members from around the state met in Columbus this past March for a "Day at the Legislature," an annual event designed to raise the political consciences of physician spouses.

Those attending this year's event were met by the staff of the Ohio State Medical Association's Legislative Department. Director Brent Mulgrew and assistants Rick Ayish, Eric Burkland and Jennifer O'Brien provided a list of bills being considered as well as hearing times so that auxiliaries could attend those hearings which specifically interested them.

During lunchtime, legislators and auxiliary members joined together for a chance to discuss and exchange viewpoints. Pictured on these two pages are some of those who attended.



Mr. Rick Ayish of the OSMA Legislative Department discusses a point with Representative Eugene Branstool (D-Utica).

Mr. Rick Ayish, OSMA Legislative Department, Senator Tom Van Meter (R-Ashland) and Mrs. Millie Murphy.





Representative Tom Carney (D-Boardman) and Mrs. Barbara Jacobson, Mahoning County.



Representative David Karmol (R-Toledo) answers questions from Lucas County Auxiliary President, Mrs. Dee Talmage.



Senator Jerry Stano (D-Parma) and Mrs. Pamela Wamsley, Cuyahoga County, listen to other views being exchanged at the table.

IS GOVERNMENT INTRUDING?

By Rebecca J. Doll



Ohio Supreme Court Chief Justice
Frank D. Celebrezze

Editor's Note:

Concern is building among the public about government intrusion into the everyday lives of citizens. In this month's Journal interview, Ohio Supreme Court Chief Justice Frank D. Celebrezze discusses government and the individual citizen, the responsibilities of each and the role each must play to insure the protection of individual rights and freedoms while also meeting the demands society places on government.

OSMA JOURNAL: There seems to be a growing feeling on the part of the public that government is becoming too involved in our daily lives, yet at the same time we also seem to be seeing the public demanding more from government. Is this your impression?

CHIEF JUSTICE FRANK D. CELEBREZZE: It would appear that people come to government looking for help and I suppose there's a widespread feeling that government is supposed to have the answer. When it doesn't have the answer people get dissatisfied with government and the aid they thought they were entitled to receive from government.

JOURNAL: A public opinion poll dated December 1978, made the statement, "People like me don't have any say about what the government does," and asked people to agree or disagree with it, and 57% of those polled agreed. Is this a legitimate complaint?

"I don't want to criticize people, but saying they have no input into government is a cop-out."

CHIEF JUSTICE: I don't want to criticize people, but saying they have no input into government is a cop-out. Government is run by people who are elected by the voters and I think most people who are elected will listen to the constituency who elects them. A person who wants to make his views known has to express them. Nobody is going to come and ask him what they can do for him.

JOURNAL: Do you think most elected officials are responsive to the needs and wishes of their constituency?

CHIEF JUSTICE: I would say that if the constituency makes its needs known, most elected officials will respond, if for no other reason than self-preservation.

JOURNAL: What's the best way for people to become involved in government?

CHIEF JUSTICE: I personally always respond to a letter. I can't give legal advice, but I always acknowledge the receipt of a letter.

JOURNAL: There is a growing feeling among many people that decisions which affect their lives increasingly are being made not by the elected officials, but by entrenched bureaucrats who do not have to be responsive to the electorate. Is this having an effect on the ability of government to be responsive?

CHIEF JUSTICE: Of course there are a lot of jobs, such as civil service, where they become entrenched because of the years they've been there and they become impossible to dis-

lodge. And government, which really is the people, helps cause this by allowing people to become certified under the civil service and making it next to impossible to fire or remove them. A good part of that lies with the system and that's a system that was adopted by the people.

In this country, people react to things more than they initiate. They respond to crises. Consequently, you have a system overburdened with permanent types such as in the civil service and when the public becomes dissatisfied, then they'll change it. Until that happens, you're going to continue to have a lot of people certified as civil servants who are sitting around waiting for payday.

The U.S. Supreme Court just ruled in a case, in Maryland I think, and said that a newly elected public official can't fire anybody and if you can't fire, what's the sense in hiring a new head? That's why a lot of people replace public officials. They're looking for someone to replace all that dead wood and get something concrete in the way of management.

JOURNAL: Do you think this type of system ties the hands of many elected officials in the sense that they can't get anything done?

CHIEF JUSTICE: Civil service does. I do think there are lots of jobs for which people should be certified and be able to work without the need to participate in politics. For example, any job which does not involve policy-making decisions or fiduciary decisions where they're acting for

their boss would seem to have no harm in being certified.

JOURNAL: Often, don't we see a law passed in the legislature, then it is sent to an agency where people other than elected officials promulgate the rules and regulations, and that's where we often have problems?

CHIEF JUSTICE: There's no question about that. You have to keep in mind that the rule-making powers, in order to be delegated, must be contained in the legislation and the people, through lobbying, obviously affect what the legislation says.

JOURNAL: There is also great concern being expressed lately about the powers of certain regulatory agencies such as the Federal Trade Commission. Is this a legitimate concern?

CHIEF JUSTICE: Obviously the FTC is getting into areas it hasn't previously been and unfortunately for many professional people they are becoming the subjects for some investigations. The FTC now is making a survey of the legal profession and it has caused a great deal of consternation among practicing lawyers.

JOURNAL: Are we, as a people, asking too much from our government?

CHIEF JUSTICE: I don't think there is any doubt that people are asking more and more from government. It's almost a cradle-to-grave supervision or existence that they are seeking. But government, at the same time, often advertises that it can do something about every problem. And usually the solution involves throwing

money at the situation, and this doesn't work in times like these. That's what government has been doing for years and I can't see where it has solved a lot of our problems. **JOURNAL:** What then should government be doing to solve our major problems?

CHIEF JUSTICE: The key is a happy mix where the individual has a personal responsibility to assist in taking care of himself and, where there are truly needy people, the government is in a position to assist them. But for government to assume charge and control over the daily lives of people, I don't think that's the purpose of government.

JOURNAL: What is the purpose of government?

CHIEF JUSTICE: The purpose of government is to provide some semblance of order in society, to provide men and women with the opportunity to educate themselves, to provide housing for their families, to provide a future for their children. That may be utopian and unobtainable but that's as I see it.

JOURNAL: Public opinion polls consistently list inflation, energy, crime, and unemployment as the major problems which concern the public, yet government does not seem to be able to confront these issues. Has government lost the ability to respond to the needs and concerns of people?

CHIEF JUSTICE: As far as crime goes, it seems to me that the local people, the so-called libertarians, they don't like crime, but they don't want to punish anybody for crime. And sooner or later, someone's going to have to exercise some authority and put these people in jail.

JOURNAL: And wouldn't that "somebody" be the courts?

CHIEF JUSTICE: Well, that's the function of the courts, yes.

JOURNAL: Are the courts not punishing as they should be?

CHIEF JUSTICE: Punishment should be a deterrent, shouldn't it? It's not supposed to be in retribution,

it's supposed to deter crime by setting an example. And I'm not so sure it is a deterrent now. At least to me it's obvious that people aren't fearful of being punished by being put in prison.

JOURNAL: Does that go back to your previous statement that not enough people are being punished for the crimes they commit and more should go to prison?

CHIEF JUSTICE: I don't think there are enough prisons to go around. If the public wanted more prisons they'd have to pay for them and with the present economy, I don't think the public is anxious to tax itself any more.

"It seems the public on one hand thinks there's too much government, and, on the other, demands more from it each day."

JOURNAL: But there is the argument that it's not so much that people don't want more taxation, but rather want to see the taxes they do pay used more wisely. Is that another one of those "cop-outs" you spoke of earlier?

CHIEF JUSTICE: I don't think it's a cop-out. I think it's a criticism of government. But, like Will Rogers once said, maybe the public ought to be happy they're not getting all the government they're paying for. It seems the public on one hand thinks there's too much government and, on the other, demands more from it each day.

JOURNAL: Why that dichotomy?

CHIEF JUSTICE: It seems to me sometimes that people have lost their way and they're looking for somebody to provide them shelter, but by the same token want to maintain their independence and dignity as human beings. When you give up something in order to obtain something else, the compromise has to be fulfilled.

JOURNAL: Have we lost our way because of lack of leadership in this country today?

CHIEF JUSTICE: There's no question that in this country we are suffering from a serious lack of leadership. Everybody who is in a position of leadership is worrying about how they can perpetuate themselves instead of doing something while they're there. I've been an advocate a long time of limiting the number of terms a congressman, senator, or any elected official can serve, including judges. Maybe we all ought to serve two terms and then get out and let someone else come in and do it, instead of sitting around and your only

thought is, how am I going to stay here next year. Holding the job becomes the career rather than doing something while you're holding the job.

JOURNAL: Would this help generate more leadership?

CHIEF JUSTICE: If nothing else, it would sure allow for more people to take part in the government. Whether or not they would do any more remains to be seen. But it would surely generate more people with an interest in government to do something in government.

JOURNAL: Several commentators have made the statement during the current primary elections that to be elected today a politician cannot take a stand on the major issues, because he must appeal to too many special interest groups. Is that a valid statement in your judgment?

CHIEF JUSTICE: They (politicians) have been doing that for a long time. It seems to me that's what a leader is supposed to do—take a stand on the issues, and if he makes the wrong

stand, in a democracy, he should be voted out. You can't allow a democracy to drift, it just doesn't work that way, and that's what's going on right now. Eventually we're going to get ourselves in a corner.

A good example is the current oil situation. This country runs on oil. The automobile has got to be about 30% of the economy. And if you can't take your automobile on the street, there's not much sense in buying one. The effects of that are just beginning. Government is supposed to plan for the future, and it would seem to me that the government should have known a long time ago that to rely on importing more than half of all fuel would not work for long. It can't unless you control half the world like England did at one time. But if that outside source decides it doesn't want to give you that fuel, you're in a lot of trouble.

JOURNAL: What will all of this lead to?

CHIEF JUSTICE: I think people are going to look for alternative forms of

government. They're going to start looking for someone they think has all the answers.

JOURNAL: In addition to voting, what else can people do to let government know they're dissatisfied?

CHIEF JUSTICE: They can take an interest in who the candidates are. People don't educate themselves to see which candidate really represents their views. And that goes along with people not expressing their views to the candidate once he gets elected.

JOURNAL: If someone were to say to you, "I'm just one person and I have no say in my government any longer. I vote, but that doesn't mean anything," what would your response be?

CHIEF JUSTICE: I say that if you don't become involved in your government and you give up your right to vote, or vote away your right to vote, you're going to lose not only your system of government but your freedom along with it. There's plenty of evidence from past cultures that freedom has to be continually watched

or it can be lost. There are those who are willing to exchange their freedom for a complacent life.

JOURNAL: A complacent life in which government does everything for them? ..

CHIEF JUSTICE: That's exactly what I'm saying.

JOURNAL: Many groups now form consortiums and lobby government on the issues that are important to them. Is this a legitimate form of involvement in government?

CHIEF JUSTICE: I really believe that people organized to pressure the legislature or Congress for measures which they believe are beneficial to them is a legitimate exercise in government. How can you expect a legislator or Congress to know what's going on unless someone gives them the information? The word lobbying has a poor connotation, but I think the exercise of lobbying is probably beneficial in the long run to the public at large. At least it's better than no involvement at all.

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The Lupus Band Test

Craig G. Burkhart, M.D.

The lupus band test is a simple and convenient laboratory test for lupus erythematosus. The detection of immune complexes in normal-appearing skin at the dermal-epidermal junction is useful in confirming the diagnosis of lupus erythematosus. Although the diagnostic significance of the lupus band test is well accepted, the prognostic value of the test is highly controversial.

DIRECT IMMUNOFLUORESCENT technics have been used in the study of systemic lupus erythematosus (SLE) since 1963 when Burnham, Neblett, and Fine¹ reported the localized deposition of immunoglobulin and complement at the dermal-epidermal junction in the skin of lupus patients. In addition to SLE, immunofluorescence has been performed in various dermatologic disorders with a subepidermal band of immunofluorescence reported in over 20 different dermatologic states.²

Immunoglobulin and complement components have been found at the dermal-epidermal junction of clinically involved and uninvolved skin in patients with SLE. The later immunofluorescent test of normal-appearing skin in a patient with SLE has been called the lupus band test (LBT). In the past there has been unnecessary ambiguity in the literature whether the LBT applies to clinically involved and uninvolved skin, or only to the uninvolved skin of patients with SLE.²⁻⁵ By eliminating the immunofluorescent testing of clinically involved skin from the definition of the LBT, the test becomes more specific and

meaningful. The immunofluorescence of involved skin at the dermal-epidermal junction is seen with numerous dermatologic disorders, whereas the immunofluorescence of clinically uninvolved skin (LBT) is an excellent diagnostic test for lupus. The two immunofluorescent tests should be separate and the difference clearly understood.

Immunoglobulins (IgA, IgG, and IgM), C1q, C3, C4, properdin, C3 proactivator, and albumin have been found in the subepidermal band of immunofluorescence in SLE.⁶⁻⁸ Thus, both the alternate and classic pathways of complement activation appear in the skin of lupus patients.

The LBT is positive in 36% to 55% of patients with SLE.^{1,3-5,9-11} The detection of immunoglobulin and complement subepidermally in normal-appearing skin is a useful, highly specific diagnostic test of SLE.^{2-6,9-17} It should be noted that only a positive LBT is of diagnostic assistance, as a negative test does not rule out SLE.

False positive LBTs have proved to be quite rare. Burnham⁴ performed the test in 70 normal controls and 74 patients with either a connective tissue disease other than SLE, polymorphous light eruption, Jessner's benign lymphocytic infiltrate, or a drug reaction. Not a single false positive LBT was found in this study. Grossman⁹ was unable to detect any subepidermal immunofluorescence in nine patients with rheumatoid arthritis, nor in five patients with antinuclear-antibody-positive connective tissue disease other than SLE. One patient out of 18 with drug-induced lupus had a positive LBT. A case of rheumatoid arthritis with a positive LBT has been reported.³ Bullous pemphigoid⁴ and dermatitis herpetiformis¹⁸ may have positive immunofluorescence at the dermal-epidermal junction of normal skin, however, the clinical presentation would rule out SLE.

Although the diagnostic significance of the LBT is well accepted, the prognostic value of this test is highly controversial. Burnham and Fine⁴ were the first to report on this subject. In 44 patients with SLE, they found that a positive LBT correlated with a more severe disease course and a threefold increase incidence of kidney involvement. Renal biopsies were not performed in the majority of these cases as the renal pathology was measured by urinary sediment and creatinine clearance.

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Dr. Burkhart, Toledo, Assistant Professor of Dermatology; and Acting Head, Division of Dermatology, Medical College of Ohio.

Submitted October 31, 1979.

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Gilliam, et al¹⁰ further supported these findings in a study of 42 lupus patients in which 91% of the patients with a positive LBT had a depressed total complement level. He reported 70% of patients with a positive LBT had laboratory evidence of renal disease by urinary sediment and creatinine clearance, while 31% with a positive LBT had negative urinary studies. On biopsying those patients with abnormalities of urinary sediment, he found that 81% of patients with a positive LBT had more severe forms of lupus glomerulonephritis (proliferative or membranous glomerulonephritis), while 23% of patients with mesangial or normal renal histology had a positive LBT. His findings of a relationship between the LBT and the more severe forms of lupus nephritis matched the later observations of Dantzig, et al.¹² Pennebaker, Gilliam, and Ziff¹⁹ found the type of immunoglobulin detected at the dermal-epidermal junction was a more specific indicator of the severity of the disease course, with a predominance of IgG signifying a worse prognosis.

On the other hand, Caperton, et al,⁵ Schrager and Rothfield,⁸ and Grossman, et al,⁹ have reported no correlation between the LBT and the presence of systemic involvement. One of the more damaging reports on the prognostic value of the LBT was reported by Wertheimer and Barland.³ They examined 53 patients with SLE with laboratory evaluations including renal biopsy. Of the 22 patients with histologic active renal disease, 55% had a positive LBT while 45% had a negative LBT. In addition to finding no association between the LBT and the renal histology, they further observed no correlation with complement levels, nor with anti-nDNA antibody levels. Moreover, he found by repeating the LBT that the test frequently became positive after successful suppression of the disease activity.

In trying to correlate any test including the LBT with renal involvement in SLE, it must be appreciated that the pathologic understanding of lupus nephritis is presently under further investigation. Many nephrologists now believe that by performing histologic, immunofluorescent, and electron microscopic studies on renal biopsy specimens, all patients with SLE will reveal evidence of kidney involvement.²⁰⁻²² By doing serial renal biopsies, it also has become evident that transformations among the various types of lupus nephritis (mesangial, glomerulonephritis, focal proliferative glomerulonephritis, diffuse proliferative glomerulonephritis, membranous glomerulonephritis, and minimal glomerular alterations) readily occur. Even the prognosis of the several morphologic forms of lupus nephritis is under dispute.^{20,21,23} It would seem that the clinical course of the various pathologic findings in lupus nephritis must be determined more carefully before any specific laboratory test can be correlated with renal involvement.

In summary, although the LBT is a useful adjunct to other tests in the diagnosis of SLE, the test has not proven to correlate with the severity of the renal disease nor the type of glomerulonephritis in any way that is clinically useful. One cannot rely on the LBT to determine the absence of severe renal disease by a negative result nor the presence of lupus nephritis by a positive LBT. To establish

accurately the nature of any renal disease at any particular time, a renal biopsy is required. Although a relationship may exist between a positive LBT and the severity of the disease, it does not supplant the need for clinical and laboratory follow-up.

References

1. Burnham, TK, Neblett, TR, Fine, G: The application of the fluorescent antibody technic to the investigation of lupus erythematosus and various dermatoses. *J Invest Dermatol* 41:451-456, 1963.
2. Monroe, EW: Lupus band test. *Arch Dermatol* 113:830-834, 1977.
3. Wertheimer, D, Barland, P: Clinical significance of immune deposits in the skin in SLE. *Arthritis Rheum* 19:1249-1255, 1976.
4. Burnham, TK, Fine, G: The immunofluorescent "band" test for lupus erythematosus: III, Employing clinically normal skin. *Arch Dermatol* 103:24-32, 1971.
5. Caperton, EM, Jr., Bean, SF, Dick, FR: Immunofluorescent skin test in systemic lupus erythematosus. *JAMA* 222:935-937, 1972.
6. Baart De La Faille-Kuyper, EH, Cormane, RH: The occurrence of certain serum factors in the dermal-epidermal junction and vessel walls of the skin in lupus erythematosus and other (skin) diseases. *Acta Derm Venereol* 48: 578-588, 1968.
7. Jordon, RE, Schroeter, AL, Winkelmann, RK: Dermal-epidermal deposition of complement components and properdin in systemic lupus erythematosus. *Br J Dermatol* 92:263-271, 1975.
8. Schrager, MA, Rothfield, NF: Clinical significance of serum properdin levels and properdin deposition in the dermal-epidermal junction in systemic lupus erythematosus. *J Clin Invest* 57:212-221, 1976.
9. Grossman, J, Callera, ML, Condemi, JJ: Skin immunofluorescence studies on lupus erythematosus and other antinuclear-antibody-positive diseases. *Ann Inter Med* 80: 496-500, 1974.
10. Gilliam, JN, Cheatum, DE, Hurd, ER, et al: Immunoglobulin in clinically uninvolved skin in systemic lupus erythematosus: association with renal disease: *J Clin Invest* 53:1434-1440, 1974.
11. Pohle, EL, Tuffanelli, DL: Study of cutaneous lupus erythematosus by immunohistochemical methods. *Arch Dermatol* 97:520-526, 1968.
12. Dantzig, PI, Mauro, J, Rayhanzadeh, S: The significance of a positive cutaneous immunofluorescence test in systemic lupus erythematosus. *Br J Dermatol* 93:531-537, 1975.
13. Percy, JS, Smyth, CJ: The immunofluorescent skin test in systemic lupus erythematosus. *JAMA* 208:485-488, 1969.
14. Lief, PD, Barland, P, Bank, N: Diagnosis of lupus nephritis by skin immunofluorescence, in the absence of extra-renal manifestations of systemic lupus erythematosus. *Am J Med* 63:441-448, 1977.
15. Chorzelski, T, Jablonska, Blaszczyk, M: Immunopathologic investigations in lupus erythematosus. *J Invest Dermatol* 52:333-338, 1969.
16. Burnham, TK, Fine, G: The immunofluorescent "band" test for lupus erythematosus: I. Morphologic variations of the

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Primary Excision: An Additional Indication for Hospitalization in Minor Burn Cases

Sidney F. Miller, M.D.
Robert K. Finley, Jr., M.D.
Sandra Alkire, RN

From 1975 to 1978, 191 patients with burns involving less than 20% of the body surface area were admitted to Miami Valley Hospital Regional Burn Unit. The general indications for hospitalization of patients with smaller burns, as well as our experience with primary excision in these patients, is discussed.

THE GENERAL INDICATIONS for hospitalization of patients with smaller burns, eg, those involving less than 20% of the body surface area, are: (1) burns involving the hands, feet, or perineum; (2) burns in which the possibility of an associated inhalation injury exists, particularly in patients who are burned in a closed space, or have burns of the face, head, or neck, carbonous sputum, singed nasal hair, or soot in the mouth or oropharynx; (3) complicating medical problems; and (4) burns of the aged and in the very young child.

Primary excisional therapy has been shown to be beneficial in the burn patient.¹ Previous reports suggest

primary excisional therapy is feasible and results in decreased morbidity and a shorter hospital stay with more rapid return to function.²⁻⁸ The experience in our burn unit with primary excisional therapy in smaller burns suggests this additional consideration for hospitalization in those patients.

Review

From 1975 to 1978, 191 patients with burns involving less than 20% of the body surface area, were admitted to the Miami Valley Hospital Regional Burn Unit. The Table shows the indications for admission of these patients. The average size of burns was 7.2% and their average age was 34.6 years. There were no mortalities in this group.

Of the 191 patients, 84 required no surgical procedures during their hospitalization, and were treated with local wound care and debridement only. One hundred and seven (56%) required some type of surgical procedure during their hospitalization. Seventy-one required one grafting procedure, and 36 required multiple grafting procedures. These 36 had 101 grafting procedures for an average of 2.8 procedures per patient. Forty-five (24%) were admitted because of the presence of small but full-thickness burns, and it was felt that early excisional therapy and primary grafting would be beneficial.

Dr. Miller, Dayton, Active Staff, Miami Valley Hospital; Associate Director of Education, Department of Surgery, Miami Valley Hospital; Assistant Director, Burn Unit, Miami Valley Hospital; and Assistant Clinical Professor, Department of Surgery, Wright State University School of Medicine.

Dr. Finley, Dayton, Active Staff, Miami Valley Hospital; Director of Education, Department of Surgery, Miami Valley Hospital; Director, Burn Unit, Miami Valley Hospital; and Clinical Professor, Department of Surgery, Wright State University School of Medicine.

Ms. Alkire, Dayton, Registered Nurse, Clinical Coordination, Burn Unit, Miami Valley Hospital.

Submitted September 18, 1979.

Indications for Admission of 191 Smaller Burn Cases at Miami Valley Hospital Regional Burn Unit (1975-1978)

Location (hands, feet, perineum)	64 (34%)
Full thickness burns needing surgery	45 (24%)
Chemical or electrical injuries	36 (19%)
Related medical problems/age	27 (14%)
Possible inhalation injury	19 (10%)

Discussion

Primary excisional therapy has been practiced at Miami Valley Hospital Regional Burn Unit since 1975. The rationale for this form of therapy has been stated previously. Prior to the advent of better topical antibiotic agents, the burn eschar was noted to separate by subeschar infection usually within three weeks. Many of the newer topical antibiotic agents inhibit the colonization of the burn wound and thereby delay eschar separation and subsequent debridement and grafting.

Patients are admitted and resuscitated as indicated, however, in most of these small burn cases no resuscitation is required. Patients are prepped for the operating room either on the day of admission or the following day as an elective procedure. All obvious full-thickness burn is excised as well as a small rim of partial-thickness burn or normal skin. This rim of tissue is excised with the full-thickness burn to insure that all nonviable tissue is removed, thereby avoiding the later necessity for additional skin grafting. Hemostasis is accomplished by accurate use of the coagulating electrocautery to avoid leaving foreign suture material in the base of the wound. A split-thickness skin graft is harvested and meshed with the Tanner mesher and applied to the excised area. The grafts are held in place either by the use of skin staples, steri-strips, or the wound dressing. On flat stable body surface areas such as the chest, abdomen, upper thigh, and back, the dressing holds the graft in place. In areas where excessive mobility exists, skin staples are used because they are easy to apply and nonreactive.

Of the 107 patients treated surgically in our burn unit, 66% required a single operative procedure. Their average length of hospital stay was seven to ten days and the majority of these patients were able to return to work within four weeks of their burn injury.

Summary

Small full-thickness burns are amenable to primary excisional therapy. Primary excision and grafting should be a consideration in the initial evaluation of patients with small burns. Most of these small burns can be treated on an ambulatory basis with later hospitalization for debridement and grafting, however, decreased morbidity and an earlier return to function can be expected by the application of primary excisional therapy. Primary excision performed within 24 to 48 hours of the burn injury allows the patient to follow a hospital course which approximates that of an elective admission, with a hospital stay averaging seven to ten days.

References

1. Finley RK, Jr, Miller SF, Shumaker S: Immediate excision of burn wounds. *Am Surg* 44:421-423, 1978.
2. Cramer LM, McCormack RM, Carroll DB: Progressive partial excision and early grafting in lethal burns. *Plast Reconstr Surg* 30:595-599, 1962.
3. Haynes BW, Jr: Early excision and grafting in third degree burns. *Ann Surg* 169:736-747, 1969.
4. Jackson D, Topley E, Cason JS: Primary excision and grafting of large burns. *Ann Surg* 152:167-189, 1960.
5. Janzekovic Z: A new concept in the early excision and immediate grafting of burns. *J Trauma* 10:1103-1108, 1970.
6. MacMillan BG: Early excision of burns. *J Trauma* 7:75-79, 1967.
7. Moncrief JA, Switzer WE, Rose LR: Primary excision and grafting in the treatment of third-degree burns of the dorsum of the hand. *Plast Reconstr Surg* 33:305-316, 1964.
8. Taylor PH, Moncrief JA, Pugsley LQ, et al: The management of extensively burned patients by staged excision. *Surg Gynecol Obstet* 115:347-352, 1962. ☆☆☆

The Current Status of Gynecologic Microsurgery

William Copeland, Jr., M.D.
Moon H. Kim, M.D.

We have seen considerable progress in various surgical specialties as a result of microsurgery. Gynecologic microsurgery is utilized extensively for reconstructive operations on fallopian tubes. The current status and advantages of microsurgery are reviewed, and our experience at The Ohio State University Hospitals is presented.

THE RECENT ADAPTATION of microsurgical technique to the field of gynecologic infertility provides exciting promise to an area where results previously have been desultory. Microsurgery could be defined as surgery performed under magnification provided by an operating microscope. Microsurgical techniques were initially devised for the field of otolaryngology, with subsequent incorporation into the specialties of ophthalmology, vascular surgery, and plastic surgery. Recently, neurosurgeons, urologists, and gynecologists have utilized them to improve the outcome of established procedures and develop new techniques. Currently, microsurgery in gynecology is limited somewhat to reconstructive operations

on fallopian tubes. However, its clear advantage has replaced conventional methods of tuboplasty in a short period of time, and its potential use in other gynecologic surgery is being explored. The purpose of this paper is to present a review of the current status of gynecologic microsurgery and a preliminary result of our animal studies at The Ohio State University Hospitals.

Microsurgical Instruments

With the advent of microsurgery, new equipment has been developed and adapted to aid technical performance. Included in these developments are magnification systems, microinstruments, and microsutures.

1. *Magnification systems* utilized at the present time are the operating microscope and operating loupes (glasses that can achieve 2.5X to 6.0X magnification). The operating microscope is used most advantageously in gynecology for static surgery in a single field, such as an end-to-end reanastomosis of the fallopian tube or fimbrioplasty. The microscope affords steady visualization without change in depth of focus. It also provides the ability to change magnification (up to 40X), as needed, to improve precision in technique. Some disadvantages are expense and size, which may cause technical problems in the operating room. Operating loupes are suitable for a larger surgical field requiring frequent changes in depth of focus. They are successfully used in reconstructive ovarian surgery and lysis of diffuse pelvic adhesions. Although they are relatively inexpensive, the limited magnification (usually fixed at one magnification up to 6X) clearly is disadvantageous.

2. *Microinstruments* have evolved from necessity because of the restrictive size of the operative field (2 x 2

Dr. Copeland, Columbus, Chief Resident and Clinical Instructor of Obstetrics and Gynecology, The Ohio State University College of Medicine.

Dr. Kim, Columbus, Professor of Obstetrics and Gynecology, and Director of Division of Reproductive Endocrinology and Infertility, The Ohio State University College of Medicine.

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cm). Fine tip forceps, scissors, and needle holders are essential for precise handling of delicate tissue. These microsurgical instruments allow surgeons to avoid unnecessary tissue damage, which can cause adhesions. Microcautery has been used with excellent results to secure hemostasis. This instrument has been refined and developed into a fingertip-controlled, bipolar cautery unit that minimizes trauma and thermal damage of tissue. A needle-point device also is useful for lysis of adhesions. Thorough control of hemostasis is the most important key to success of microsurgery, and it is possible only through these new cautery systems.

3. *Specialized suture materials* have been adapted readily to this field. Gynecologic microsurgical sutures range from size 6-0 to 10-0. Initial suture materials were of chromic or plain gut of 6-0, but these were found to create extensive tissue reaction and adhesion formations. Presently employed materials are synthetic sutures, and include nylon or absorbable polyglycolic acid sutures, which cause minimal tissue reactivity. Atraumatic, tapered needles are used with sizes in the 100-micron range. Thus, use of these microsutures minimizes trauma on delicate tissue.

Clinical Applications

Tubal factors account for 50% of all female infertility. Of this total, 85% are secondary to tubal occlusion, and the remaining 15% result from peritubular adhesions, which interfere with normal tubal motility and function. In view of these figures, it is clear that surgery offers numerous benefits in patients with tubal infertility. On the basis of our experience at The Ohio State University and those of other investigators, four general categories of reconstructive adnexal surgery are considered.

1. *End-to-end reanastomosis* of the fallopian tube has been utilized in cases of pathologic obstruction and in reversal of previous tubal sterilization procedures. Female sterilization represents a major method of contraception presently used throughout the world. With the increase in sterilization procedures, there has been a concomitant increase in the demand for sterilization reversal. The figure could be as high as 1% of all sterilizations performed, which would account for nearly 6,000 patients per year in the United States.¹ Motivation for sterilization reversal includes change of marital status, increased financial capabilities to raise more children, or previous loss of a child.² In a review of the available literature through 1977, Berger and Keith documented an intrauterine pregnancy rate of 31% for conventional end-to-end tubal anastomosis. The ectopic pregnancy rate was 7%.³ Preliminary studies with microsurgical technic demonstrate an intrauterine pregnancy rate of 60%, and an ectopic pregnancy rate of 3%.³ Individual series include those of Diamond,⁴ who demonstrated a 62% intrauterine pregnancy rate, and Gomel,⁵ who reported an 80% intrauterine gestation rate after two or more

years of postoperative follow-up. The ectopic pregnancy rate remains less than 5%.

2. *Uterotubal anastomosis* of the fallopian tube previously had been accomplished by use of a reamer or partial cornual resection and subsequent implantation of the tube into the uterus. This procedure usually was accompanied by significant bleeding and anatomical distortion. Recent literature review showed the intrauterine pregnancy rate to be a disappointing 32% for these cases.³ The ectopic pregnancy rate was 2%. Careful examination has shown that the interstitial portion of the tube rarely is occluded by any sterilization procedure, including diathermy. Winston⁶ has demonstrated a microsurgical technic of dissecting the cornual portion of the uterus until a patent segment of interstitial tube is available. This is followed by a microsurgical end-to-end reanastomosis with the remaining portion of distal fallopian tube. This procedure also has been utilized in patients with inflammatory disease of the isthmus. The pregnancy rate using this method was approximately 60%.

3. *Fimbrioplasty or salpingostomy* has proven to be the most frustrating area of reconstructive tubal surgery to date. Patency rates with conventional technics range from 53% to 84%, but pregnancy rates are only 7% to 39%. Ectopic pregnancy rates ranged from zero to 13%.⁷ This would seem to indicate that although patency was preserved, the normal function of the tube was impaired in some fashion. In a review of five studies involving microsurgical technic,⁸ the patency rate was over 93% and the pregnancy rate was 46.3%. The overall ectopic pregnancy rate was 5.8%, but one series has documented an 18% incidence of ectopic gestation.⁹ Further studies will be necessary to elucidate the potential long-term benefits of microsurgery in this aspect of tubal surgery.

Experimental Applications

In the initial experimental applications of tubal microsurgery, animal models were used to simulate possible results in future human surgery.* Numerous models have been employed to date for reconstructive anastomotic procedures, but the most consistent animal model appears to be the rabbit oviduct. This has provided an excellent method of developing and refining surgical technics that subsequently have been adapted to human surgery.

Microsurgical technics also have provided an appreciation of the structural and functional complexity of the oviduct. The fallopian tube no longer can be regarded as a conduit for the passage of gametes. Sperm transport, capacitation, ovum pick-up, ovum transport, fertilization, embryo transport, and embryo nourishment are among

*Animal studies in this report are supported partly by a grant-in-aid from Davis & Geck Department of American Cyanamid Company, Wayne, New Jersey 07470.

Gynecologic Microsurgery (continued)

the preimplantation processes occurring within the oviduct. Microsurgery and microscopy can serve to evaluate alterations in these functions by surgical or pharmacologic methods. These findings are important potentially in contraceptive research as well as evaluation of patients desiring reversal of tubal sterilization. They also may be applicable in understanding the pathophysiology of tubal infertility or pregnancy complications such as ectopic gestation. Therefore, the recent use of tubal microbiopsy for electron or scanning microscopy has been used to define tubal pathology, and to utilize these results for prognosis of surgical therapy.

The ultimate extension of tubal microsurgery is tubal transplantation. The technics have been studied extensively by Cohen and others in animal models.¹⁰ Isolated reports of human tubal transplants have been published, but no pregnancies have been achieved to date.¹¹ Tubal transplants from donors have experienced difficulties with immunologic rejection in the past, and further research is necessary before this technic can be considered as an alternative method for attaining fertility.

Animal Model

As previously discussed, the rabbit oviduct has been used extensively as a research model in tubal microsurgery. We have completed a series of tubal reanastomosis experiments in 12 New Zealand white rabbits. Each specimen underwent initial laparotomy, and bilateral tubal patency was assessed with indicator dye. One tube was used as a control, and the contralateral tube was transected. The tube ends were then reanastomosed with 10-0 nylon suture using microsurgical technic. Care was taken to avoid suturing of the mucosal layer of the tube and the reanastomosis was accomplished in two layers (muscularis and serosa). The rabbits then were mated with a proven buck, and a second laparotomy was performed in three weeks to assess tubal patency, pregnancy rates, and adhesion formation. At the second laparotomy, eight rabbits had freely patent fallopian tubes, and seven rabbits had achieved pregnancies on the operated side. One oviduct was patent, but the rabbit had failed to ovulate with coital exposure. The patency rate then is 66.7% (8/12), with a corrected pregnancy rate of 63.6% (7/11). These results favorably compare with previously published studies.¹²

Conclusion

Gynecologic microsurgery remains in its infancy at the present time, but its potential benefit in a previously unsatisfactory setting is promising. This technic certainly has demonstrated superiority over conventional methods

in reversal of tubal sterilization. It offers general improvement in operative procedures because of the precision required in the microsurgical technic. More information is required before firm statements can be made concerning the benefit in fimbrioplasty and other plastic procedures of the fallopian tube. Research in this field continues at the present time into tubal anatomy and physiology, which will benefit medical and surgical treatment of tubal disease in the future. The outlook for tubal transplantation remains guarded at the present, due to difficulties in surgical technic and medical management of the immune response, but this continues to be an exciting possibility.

Human microsurgical procedures and animal research programs continue to expand at The Ohio State University Hospitals in an effort to achieve increasingly superior results to conventional operative experiences. Undoubtedly, microsurgery requires technical expertise which is attained through extensive training and clinical experience.

References

1. Phillips JM, Hulka J, Hulka B, et al: American Association of Gynecologic Laparoscopists' 1976 membership survey. *J Reprod Med* 21:3-6, 1978.
2. Gomel V: Profile of women requesting sterilization reversal. *Fertil Steril* 30:39-41, 1978.
3. Berger GS, Keith L: Gynecologic microsurgery for proximal and midsegment tubal reconstruction after sterilization: A review and critique of the literature through 1977. In *Endoscopy in Gynecology*. Edited by J. M. Phillips. Downey, California, American Association of Gynecologic Laparoscopists, 1978, p. 432.
4. Diamond E: Microsurgical reconstruction of the uterine tube in sterilized patients. *Fertil Steril* 28:1203-1210, 1977.
5. Gomel F: Tubal reanastomosis by microsurgery. *Fertil Steril* 28:59-65, 1977.
6. Winston RML: Microsurgical tubocornual anastomosis for reversal of sterilization. *Lancet* 1:284-285, 1977.
7. *Microsurgery in gynecology*. Edited by J. M. Phillips, Downey, California, American Association of Gynecologic Laparoscopists, 1977, p. 132.
8. Marik JJ: Microsurgical repair of hydrosalpinx. In *Microsurgery in Gynecology*. Edited by Jordan Phillips, M.D. Workshop for Laparoscopy and Microsurgical Repair of the Fallopian Tube, University of California, Irvine, 1977.
9. Swolin K: Electromicrosurgery and salpingostomy: Long term results. *Am J Obstet Gynecol* 121:418-419, 1975.
10. Cohen BM: Vascularized homograft transplantation of the fallopian tube in the experimental animal. Presented at the Eighth World Congress of Fertility and Sterility, Buenos Aires, Argentina, 1974. In *Microsurgery in Gynecology*.
11. Cohen BM: Preliminary experience with vascularized fallopian tube transplants in the human female. *Int J Fertil* 21:147-152, 1976.
12. Winston RML: Microsurgical reanastomosis of rabbit oviduct and its functional and pathological sequelae. *Br J Obstet Gynaecol* 82:513-522, 1975. ☆☆☆

PATIENT EDUCATION AND COST CONTAINMENT

By Leonard P. Rome, M.D.

The cost of medical care is everybody's business. The physician, patient, hospital staff and administration, insurance carrier, industry, labor, government—virtually every segment of society, has some impact on the cost of medical care. Of all these groups, the individual patient probably has the greatest single opportunity to minimize his or her health care expenses by avoiding illness through healthful lifestyles and preventive medicine, by avoiding preventable injury through reasonable safety precautions, and by minimizing actual medical care costs through early diagnosis, treatment, and compliance with physician's instructions.

However, the burden does not rest solely on the patient. Motivating appropriate changes in behavior calls for a cooperative community-wide effort in effective patient education. Many important efforts already are being made by the Academy of Medicine of Cleveland, as well as other health agencies in this area. In some phases of patient education there is a great deal of overlap due to the number of agencies involved, while other basic needs remain generally unmet.

In order to solve this problem, the Academy's Cost Containment and Patient Education Subcommittee compiled the number of patient education activities currently in progress, listed areas which receive less emphasis or are not served at all, and developed new strategies for cost containment through patient education. The Committee's five-prong task force involved a number of participants representing a variety of health agencies. Their findings are reported in the study detailed below.

Editor's Note: Although this study involves Cleveland and the surrounding area, all county medical societies can benefit from this report by conducting their own study to determine strengths and weaknesses in their community's health education efforts.

MODIFYING LIFE STYLES

There is evidence that patient education can modify behavior when focused on a group of patients with a high

degree of personal interest in illness and treatment. Education programs in medical regimens, body weight adjustment, alcohol consumption and abuse, exercise as prescribed by the physician, smoking, anxiety and depression, periodic health appraisals based upon the physician's judgment for the individual patient should be sponsored by the county medical society in cooperation with other local health agencies.

In addition, employers should be motivated to encourage their employees to adopt more healthful life styles. Patient education films on smoking and teenage alcoholism, and printed materials on alcoholism, drug abuse, stress, and suicide are available from various organizations and should be distributed as widely as possible.

EMERGENCY MEDICAL CARE

A. The Public

At least one member of each household should know how to recognize a medical emergency, how to call for help, and how to provide first aid care prior to arrival of trained paraprofessionals. Telephone companies should be encouraged to publish a more comprehensive listing of emergency phone numbers such as poison centers, emergency squads, etc., on the inside front cover of the telephone directory.

B. The Providers

Continued efforts are needed to implement an equitable and practical hospital categorization plan for emergency care based on the judgment of the referring physician.

Municipal emergency medical services must be urged to transport patients to the appropriate hospital, not necessarily the nearest facility.

Nonemergency patients should be referred from the emergency department to an ambulatory setting for appropriate care at a lower cost. Feasibility studies should include 24-hour ambulatory care centers within the emergency room or in other appropriate regional locations.

Patient Education (continued)

The public must be educated as to the difference between emergency care and primary care.

C. The Community

Medical societies should encourage and generate financial support for innovative primary care service outside the emergency room, such as public use of industrial health clinics during nonworking hours.

ACCIDENT PREVENTION

Accidents, which by definition are preventable, represent a \$52 billion loss each year. A sustained and coordinated accident prevention program is needed in many communities and has great potential for cost effectiveness.

Plans should be developed for a more comprehensive program to be coordinated by a central agency. Consideration must be given as to what existing agency, if any, should assume this role.

HOW MEDIA MAY BE USED FOR PATIENT AND PUBLIC HEALTH EDUCATION

A. In the Hospital

- 1) Medical staff should promote closed circuit TV programs available for viewing by patients.
- 2) Programs for bedside or group viewing should be available in the form of slides, filmstrips, or videotapes.
- 3) Book carts and waiting rooms should be supplied with pamphlets on topics related to health education.
- 4) Nursing stations should have printed materials to remind viewers of audiovisual program content.

B. In Clinics

Outpatient and family clinics should be equipped for individual viewing of short informational programs as recommended by the professional staff.

C. In the Physician's Office

1) A separate area should be designated and equipped for patient viewing of audiovisual health education programs prescribed by the physician or selected by the patient.

2) Printed material should be made available to promote use of existing community health services and to reinforce content of audiovisual programs.

D. In The Community

1) Health professionals should promote and assist in health programming through public service cable television and other media.

2) Public libraries should continue their efforts to become sources of health information.

3) Hospitals should sponsor films on health topics as a community service and provide opportunities for discussion and follow-up by the public.

4) Health professionals and agencies should encourage television stations to present health topics to the community and should offer to serve as consultants to the media.

E. Promotion of Media Use By Physicians

1) Establish viewing sites and obtain equipment for hospitals, clinics, and offices.

2) Participate in your society's public relations activities and promote them to patients.

3) Encourage patients to write their questions so they may be placed in the patient's chart and answered at the time of the bedside visit.

4) Enlist the help of other health professionals in the patient education process.

Dr. Leonard P. Rome is Chairman of the Public Information Committee, Academy of Medicine of Cleveland.



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Grant Helps Elderly Maintain Independent Life

A grant received from the Robert Wood Foundation will help elderly, health-impaired residents of Summit County maintain reasonably independent life styles for as long as possible.

Summit County is the only Ohio community to receive funds for the "Health-Impaired Elderly" program, administered by the Mount Sinai School of Medicine in New York.

With Foundation support, coordinating organizations will be formed to locate elderly with health problems, assess their needs, notify agencies that can help them, and then follow up to make sure services were received.

The coordinating organization is created jointly by a government-supported Area Agency on Aging and the major voluntary organization providing services to the elderly in the community. The Ohio Commission on Aging and the Summit Seniors Team Corporation are the agencies involved with the program.

Persantine/Aspirin Reduces Second Heart Attacks

The results of the five-year PARIS study (Persantine Aspirin Reinfarction Study) reveal that taking Persantine and aspirin together after having suffered one heart attack reduces the risk of a second one by up to one third during the first two years.

The Maryland Medical Research Institute under the direction of Christian R. Klimt, M.D., Doctor of Public Health, conducted this double blind study with 2,026 patients in 16 American and four British clinical centers over a period of 44 months.

Patients selected for this study must have had a verified heart attack 8 weeks to 60 months before entrance into the program. Three specific endpoints were evaluated: coronary incidence (fatal and nonfatal myocardial infarction); coronary death; and total death (from all causes). The results indicated that Persantine and aspirin reduced coronary incidence significantly and consistently over 24 months. Aspirin was inconsistent.

However, the FDA will have to approve such use of Persantine/Aspirin before the new regimen is likely to be adopted on a widespread basis.

Florida Mediation Panel Deemed Unconstitutional

A medical mediation statute, enacted in 1975 as part of a professional liability insurance reform package sponsored by the Florida Medical Association, was recently ruled unconstitutional by the Florida State Supreme Court.

The court ruled that, "application of its rigid jurisdictional periods has proven arbitrary and capricious in operation," and said the act could not be remedied by "enlarging the jurisdictional periods or in permitting continuances or extension of time." The Court further ruled conclusively, "We are left with a statute which is intractably and incurably defective and therefore hold that . . . the medical medication act is unconstitutional in its entirety as violative of the due process clauses of the United States and Florida State constitutions."

Richard S. Hodges, M.D., FMA president, commented that the decision would no doubt aggravate an already developing crisis situation in malpractice insurance, evidenced by the rise in claims reported since 1976, and the cost per claim during that same period. He further noted that the Court's action attached even greater importance to the enactment of legislation being sponsored by the FMA that will provide for recovery of costs to the prevailing party in any civil proceedings.

Substitute Drug Recalled

The Food and Drug Administration today warned pharmacists, physicians, and consumers that a prescription diuretic called Triam-Thiazide may cause elevated potassium levels—a potentially serious health hazard.

Triam-Thiazide is the brand name for a combination of triamterene and hydrochlorthiazide that is being marketed without approval by FDA as a substitute for an approved drug called "Dyazide."

Both the approved and unapproved versions of the drug are similar in appearance. Both are maroon and white. The major difference is that the brand name "Dyazide" and the letters "SKF" appear on the approved drug.

The manufacturer that marketed the unapproved

continued on page 312

*Morris E. Chafetz, M.D.,
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Institute on Alcohol Abuse and Alcoholism,
is pleased to announce
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A. R. DE CATO, M.D., was elected president of the Ashtabula General Hospital medical staff. **S. E. HUANG, M.D.**, was elected secretary-treasurer.

ALVIN H. CRAWFORD, M.D., Cincinnati, associate professor of orthopedic surgery and pediatrics and director of orthopedics at Children's Hospital Medical Center, recently served as visiting professor at the King Hussein Medical Center, Amman, Jordan. Dr. Crawford is the first American orthopedist to receive the honor.

PAUL G. DYMENT, M.D., Painesville, was appointed chairman of pediatrics and adolescent medicine at the Cleveland Clinic Foundation.

GARY FREEMAN, M.D., Beachwood, was named director of Mt. Sinai Hospital's Department of Anesthesiology.

Newly elected officers of the Middletown Hospital medical staff are: **WILLIAM LANGWORTHY, M.D.**, president; **E. R. OCHES, M.D.**, vice president; and **CHARLES L. KRESGE, M.D.**, secretary-treasurer.

JOHN McGRAIL, M.D., Delaware, was re-elected chairman of the Delaware County Health Planning Advisory Committee.

MARGE McLARNEN, executive secretary of the Lake County Medical Society for 25 years, retired March 31. She was succeeded by **JAN VARGO**.

PAUL S. METZGER, M.D., Upper Arlington, was promoted to chief medical director in his capacity as a vice-president of Nationwide Insurance.

Members of the Hoytville United Methodist Church composed an ensemble to sing during a special service in honor of **HARRY J. MILLER, M.D.** Dr. Miller is retiring after serving the McComb community for nearly 50 years.

JOSEPH MILLER, M.D., Dayton, was re-elected chief of staff of Dettmer Hospital. Other officers include: **E. R. TORRENCE, M.D.**, vice-president, and **ROBERT SUTTON, M.D.**, assistant secretary-treasurer.

W. CLARE REESEY, M.D., Youngstown, was appointed director of the Youngstown Hospital Association Family Practice Center.

FREDERICK ROBBINS, M.D., will become new president in October of the Institute of Medicine of the National Academy of Sciences. Dr. Robbins will replace David Hamburg, M.D., who will become director of a Harvard University health policy project.

Dr. Robbins, a Cleveland pediatrician, is a graduate of the Harvard University School of Medicine, and currently serves as dean of Case Western Reserve Medical School. His duties include service as professor of both pediatrics and community health. Dr. Robbins is an active member, both past and present, of various community health committees.

WALTER W. TIMPERMAN, M.D., Indian Hill, was elected president of the Providence Hospital medical staff, Cincinnati.

Nearly 500 people attended a surprise appreciation party for **NICHOLAS M. TSALOFF, M.D.**, Akron. He was given a plaque citing "his unending dedication, perseverance, compassion and love since 1934. Given by four thankful generations . . ."

CORRECTION

The March 1980 issue of the Journal erroneously reported in its "Colleagues in the News" section that **ROBERT A. WILTSIE, M.D.**, was named clinical associate dean of medical students from the Northeastern Ohio Universities College of Medicine. Instead, Dr. Wiltsie is one of five associate deans for clinical sciences appointed by Northeastern Ohio Universities College of Medicine to serve as liaison to students enrolled in the undergraduate medical education program. The Journal regrets this error.

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NEWS (continued)

version of the drug is Premo Pharmaceuticals Laboratories, South Hackensack, New Jersey. FDA has requested that Premo recall the drug. The company has refused to do so. Accordingly, FDA has asked Premo's distributors to conduct the recall.

Grant Aids Cost Containment Efforts

A grant entitled, "Cost Awareness Begins At Home: A Continuing Medical Education Community Experiment," has been awarded to the Medical College of Ohio in conjunction with Northwest Ohio hospitals and physicians. The grant, awarded by the National Fund for Medical Education in Hartford, Connecticut, will help the Medical College of Ohio develop cost awareness teaching techniques that will be integrated into continuing medical education programs throughout the region.

CLINICAL & SCIENTIFIC (continued)

band of localized immunoglobulins at the dermal-epidermal junction in lupus erythematosus. *Arch Dermatol* 99: 413-420, 1969.

17. Tuffanelli, DL: Cutaneous immunopathology: Recent observations. *J Invest Dermatol* 65:143-153, 1975.
18. Fry, L, Haffenden, G, Wojnarowska, F, et al: IgA and C₃ complement in the uninvolved skin in dermatitis herpetiformis after gluten withdrawal. *Br J Dermatol* 99:31-37, 1978.
19. Pennebaker, JB, Gilliam, JN, Ziff, M: Immunoglobulin classes of DNA binding activity in serum and skin in system lupus erythematosus. *J Clin Invest* 60:1331-1338, 1977.
20. Appel, GB, Silva, FG, Pirani, CL, et al: Renal involvement in systemic lupus erythematosus (SLE): A study of 56 patients emphasizing histologic classification. *Medicine* 57:371-410, 1978.
21. Cavallo, T, Cameron, WR, Lapenas, D: Immunopathology of early and clinically silent lupus nephropathy. *Am J Pathol* 87:1-15, 1977.
22. Hollcraft, RM, Dubois, EL, Lundberg, GD, et al: Renal damage in systemic lupus erythematosus with normal renal function. *J Rheumatol* 3:251-261, 1976.
23. Baldwin, DS, Gluck, MC, Lowenstein, J, et al: Lupus Nephritis. *Am J Med* 62:12-30, 1977. ☆☆☆

OBITUARIES

SCHARROLD M. A. ADAMS, M.D., Lincoln, California; Ohio State University College of Medicine, 1922; age 84; died February 22; member OSMA and AMA.

WILLIAM CARROLL, M.D., Akron; Second Moscow Medical Institute, Moscow, 1933; age 72; died February 19; member OSMA.

STEPHEN FOERSTNER, M.D., Cleveland; Case Western Reserve University School of Medicine, 1921; age 83; died February 24; member OSMA.

LAWRENCE GOODMAN, M.D., Findlay; University of Michigan Medical School, 1932; age 72; died February 16; member OSMA and AMA.

JOSEPH H. HANSON, M.D., Toledo; McGill University Faculty Medical, Toronto, Ontario, 1945; age 59; died March 21; member OSMA and AMA.

JOSEPH MACYS, M.D., Cleveland; Vytauta Didziojo, University Kaunas, Lithuania, 1928; age 79; died March 13; member OSMA and AMA.

EMIL J. MECKSTROTH, M.D., Sandusky; Ohio State University College of Medicine, 1924; age 79; died February 21; member OSMA and AMA.

RUSH ROBINSON, JR., M.D., Columbus; Ohio State University College of Medicine, 1936; age 68; died March 19; member OSMA and AMA.

GORDON EDMAN SAVAGE, M.D., Xenia; Ohio State University College of Medicine, 1931; age 88; died March 6; member OSMA and AMA.

THEODORE DAVID SAWYER, M.D., Crestline; Ohio State University College of Medicine, 1934; age 75; died March 15; member OSMA and AMA.

HAROLD H. WAGNER, M.D., Dayton; University of Cincinnati College of Medicine, 1921; age 89; died February 18; member OSMA and AMA.

PAUL L. YORDY, M.D., Dayton; Ohio State University College of Medicine, 1926; age 79; died January 30; member OSMA and AMA.

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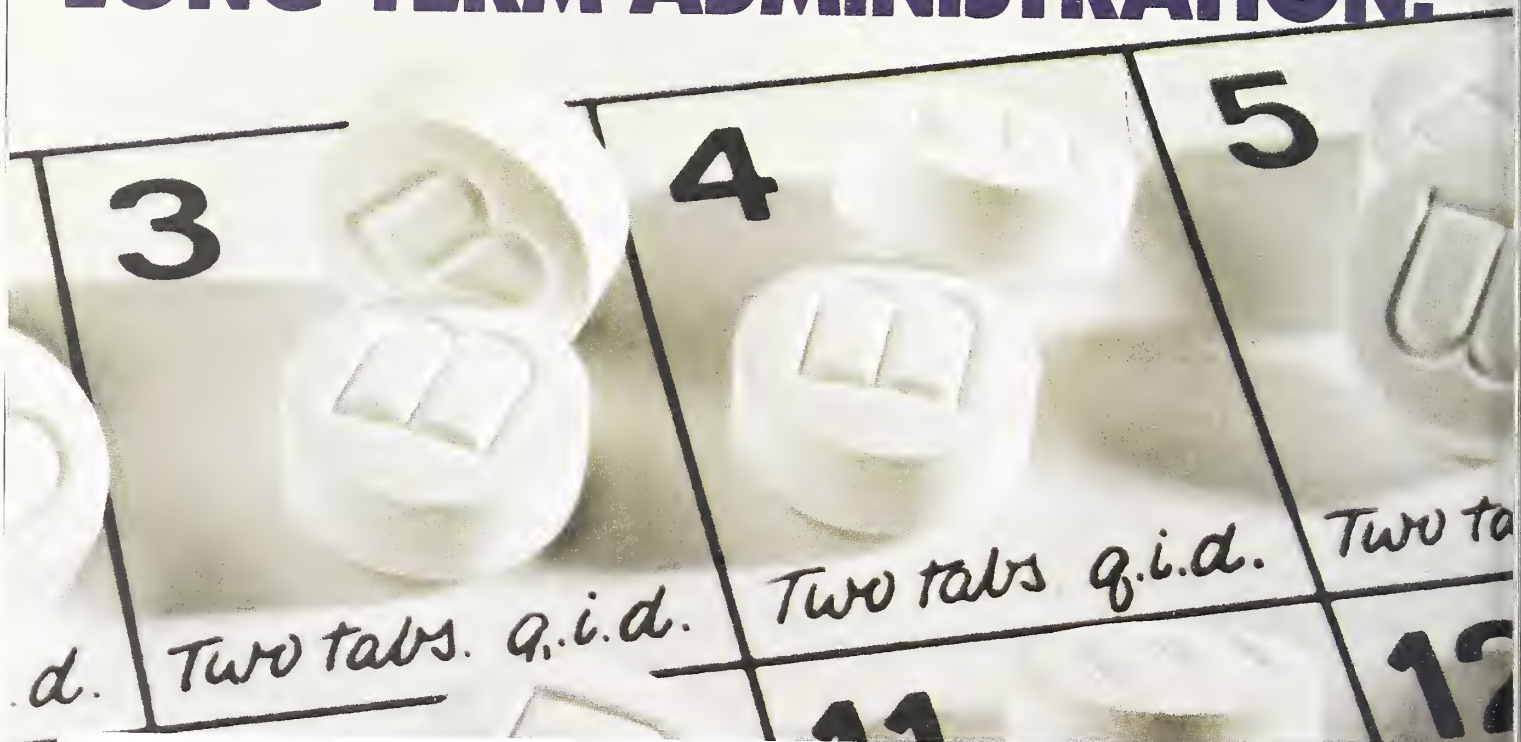
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Features

On record 344 *Rebecca J. Doll*

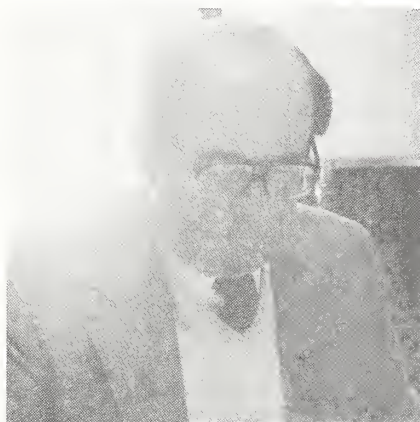
Now that malpractice suits are again on the rise, how well would your records stand up in court? James Pohlman, Esq., legal counsel to the OSMA discusses medical records — for the record — in this month's OSMA interview.



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Mid-Ohio Race Physicians: A microcosm of applied emergency medicine 346 *Charles B. Payne, Jr., M.D.* *Richard E. Nensel, M.D.* *Joseph C. Barkey, M.D.*

The authors take a look at a different aspect of emergency medicine — a practice amid the roar of revving engines at Ohio's major professional road racing course.



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The Cincinnati gamble 351 *Karen S. Edwards*

After a Colorado medical society learned the hard way that consumers just didn't want a physician directory, along comes the Cincinnati Academy of Medicine, willing to bet that someone out there did.



Robert G. Thomas, M.D.: A Presidential profile 354 *Rebecca J. Doll*

The new president of the OSMA speaks out on organized medicine, government regulation and rising health care costs.

Our Cover

Charles Payne, Jr., M.D., one of the authors of the article on Mid-Ohio Race Physicians took this picture of one of the racers during the 1977 Canadian American Challenge Cup.

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COLLEAGUES IN THE NEWS



The medical staff of Euclid General Hospital honored **WALTER FANELLI, M.D.** for 50 years of service to the hospital and his many contributions to the medical profession and the northeast community. Dr. Fanelli joined the Euclid General Hospital medical staff in 1930 and now practices in South Euclid.

SAMUEL KIEHL III, M.D., Columbus, was named director of emergency services at Riverside Methodist Hospital.

JOHN J. NEWTON, M.D., Sylvania, is president of the Ohio Division of the American Cancer Society. Representatives from every county unit, unit volunteers, and staff members met for the official kick-off of April as Cancer Control Month and the 1980 fund-raising crusade.

Newly elected members of the medical staff of Middletown Hospital are: **WILLIAM LANGWORTHY, M.D.**, president; **E.R. OCHES, M.D.**, vice-president; and **CHARLES KRESGE, M.D.**, secretary-treasurer.

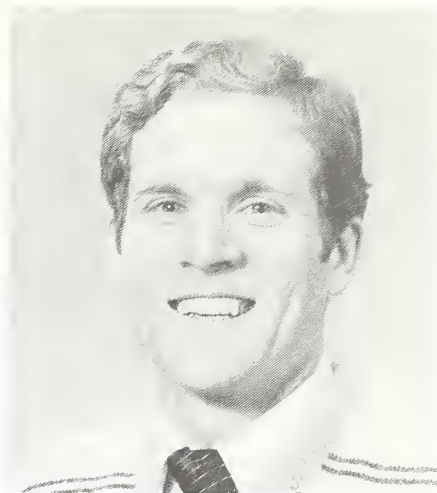
A.L. PANGALANGAN, M.D., Westerville, was elected vice-chairman of the Department of Surgery at Mount Carmel East Hospital.

LENIN RIVERA, M.D., Montpelier, was reappointed health commissioner of the Williams County Health Department.

GEORGE J. BAIBAK, M.D., Toledo, was installed as president of the Ohio Valley Society for Plastic and Reconstructive Surgery.

RICHARD BEHRMAN, M.D., Cleveland, was appointed dean of the Case Reserve School of Medicine.

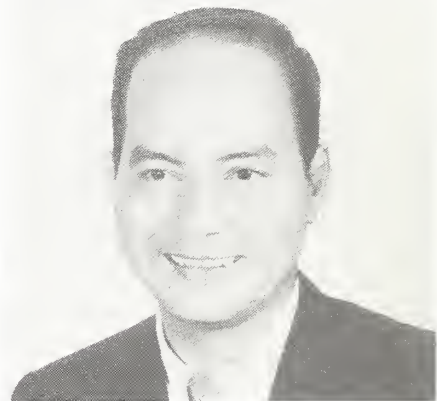
WILLIAM HUFFMAN, M.D., Cleveland, was elected president of the medical staff of Lakewood Hospital. Other officers include: **ROBERT WALLACE, M.D.**, vice-president and **MANUEL VALERA, M.D.**, secretary-treasurer.



Samuel Kiehl III, M.D., Columbus . . . directing emergency services.



George J. Baibak, M.D., Toledo . . . presiding plastic surgeon



A.L. Pangalangan, M.D., Westerville . . . vice-chairing surgery department.

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Physician guidelines help curb drug abuse

In an effort to control abuse of prescription drugs, physicians have been asked to follow voluntary guidelines when prescribing medications for their patients.

The guidelines, drafted in 1974 by the Practitioners Working Committee of the Drug Enforcement Administration (DEA), have been endorsed by the DEA, the National Institute on Drug Abuse, and five national medical organizations, including the American Medical Association.

General guidelines discuss the potential for drug abuse and dependence on prescription medicines and urge the physician to exercise good judgment in administering and prescribing controlled substances. They also ask that specific efforts be made to insure that multiple prescription orders are not being obtained by the patient from different prescribers.

Under a more specific list of guidelines, physicians are asked to:

- Prescribe medications precisely and legibly so that they may be dispensed properly by the pharmacist.
- Prescribe no greater quantity of a drug than whatever amount may be needed until the next checkup.

- Write out the actual amount of medication prescribed, in addition to giving Arabic or Roman numerals so that altering the prescription would be difficult.
- Use separate prescription blanks for each controlled substance prescribed.
- Try to make prescription orders alteration-proof.

Physicians also are reminded that they have a responsibility to inform the patient of the effects of the prescribed drug, consistent with good medical practice and professional judgment, just as the patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Over-prescribing or careless prescription writing has been blamed by many authorities for abuse of controlled drugs, such as amphetamines and barbiturates.

Other groups involved in writing and endorsing the guidelines are the American Dental Association, the American Nurses Association, the American Osteopathic Association, the American Podiatry Association, and the American Veterinary Medical Association.

Lasers cut radiation costs

A new system using laser lights to position patients needing radiation diagnosis or therapy has proven to be not only a cost-cutting measure at several hospitals using the new tool, but has improved patient care as well.

According to *Radiology/Nuclear Medicine* magazine, the new laser positioning system can achieve correct positioning almost instantly, saving time, money, and reducing the amount of radiation received by the patient.

Each laser unit generates three separate alignment marks. Two outer lines define the lateral edges of the film and a slightly heavier, center line can be aligned with the patient's spine to center the view. These laser lines are clearly visible, even under full room illumination.

A fourth line also can be added that will define the top of the lungs in relation to the film.

Learning expenses

The Medical College of Ohio soon will be infusing its educational programs with a healthy dose of medical cost awareness.

The underlying idea behind the effort is that the major responsibility for cost awareness programs rests with the physician. By instilling this awareness during the physician's training, he or she will hopefully be able to take a sustained look at the kind of care and services he provides to his patients in the future.

Several means of introducing these programs into the educational process are currently being reviewed. If the programs are introduced successfully, they may then be offered to medical colleges throughout the state, with the support of the Ohio State Medical Association.

Fat chance

To those 40 million Americans who suffer from obesity, help is on the way.

Dr. David Margules, a psychology professor at Temple University, Philadelphia, Pennsylvania, has established the National Obesity Research Foundation — dedicated to research and the exchange of diet information for those suffering from overnutrition.

"Our purpose is to support qualified investigators doing research on obesity," Margules explains.

"We will support new research and publish our findings along with previous information relevant to the problem of obesity."

"Strawberries" lead the field in Journal photographic contest

A total of 97 entries competed for recognition in this year's *Journal* Photographic Exhibit Contest. All entrants were displayed in a special exhibit at the OSMA Annual Meeting, held May 10-14 in Cincinnati, Ohio, and awards for "Best in Show" and "Outstanding Entry" were presented to the winners during the final session of the House of Delegates on Wednesday, May 14, by Judging Committee Chairman, Harry Hines, M.D.

This year's "Best in Show" award went to Mrs. Vera Kalnins, Bucyrus, for her picture entitled "STRAWBERRIES," which will be featured on next month's *Journal* cover.

Eleven entries were judged "Outstanding" by this year's judging committee. The eleven include:

"CANADIAN SUNRISE" — James Rudick, M.D., Canton
"BRAILLE MEDICAL TEXT" — George Morrice, M.D., Newark
"AUTUMN REFLECTIONS" — Joseph M. Wilson, M.D., Dayton
"STORM CLOUDS" — George W. Waylonis, M.D., Columbus
"MOSAI INFANT AND MOTHER" — O. David Solomon, M.D., Shaker Heights
"COLORADO MOONSHINE" — Lewis W. Coppel, M.D., Chillicothe
"FROST" — Vera Kalnins, Bucyrus
"PELICANS KEY WEST" — Warren W. Smith, M.D., Columbus
"BRIEF MOMENTS" — Edward Kezur, M.D., Hamilton
"JACK FROST'S MAGIC" — John C. Starr, M.D., London
"PENINSULA POST OFFICE" — Mrs. Jessica M. Mader, Silver Lake

MISCELLANEA

- Attorneys and physicians concerned with medical malpractice may wish to take the **Trial Anatomy for Lawyers Lecture Tour**, sponsored by the Medi-Legal Institute. Included in the lecture will be a unique insight to the use of medical experts in the courtroom. Tours will be conducted through Britain and aboard a cruise ship to Alaska. For information, write to the Medi-Legal Institute, 9570 Wilshire Blvd., Suite 300, Beverly Hills, CA, 90212.

- The Second National Conference on Antibiotic Review, "Practical Strategies for Antibiotic Review, 1980," will be held in Chicago, August 28-29, 1980. For details, contact Muriel Myers, Suite 114 A, 67 Peachtree Park Drive, Atlanta, GA, 30309.

- Country Programmers, Inc. of White River Junction, Vermont is offering a new "Medaccounting" system for physicians which can, the firm claims, provide immediate access to any patient's medical and billing records, as well as perform other accounting duties not yet available in other products. Interested parties should contact Ms. Diane Fay, CPI, Holiday Inn Drive, White River Junction, VT, 05001, (802) 295-9100.

- Fledgling poets may wish to try their luck in the World of Poetry's **Sixth Annual Poetry Competition**. Poems of all styles and subjects are eligible to compete for any of 50 cash or prize merchandise awards. Rules and entry forms available from World of Poetry, 2431 Stockton, Dept. N., Sacramento, CA, 95817.

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Psychiatric Glossary

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More than 1,000 definitions of psychiatric terminology and descriptions of people who have made significant contributions to the psychiatric field are included in this updated glossary, written by a special Subcommittee of the APA's Joint Commission on Public Affairs. Included in the 142-page volume are 85 commonly used abbreviations as well as tables on Commonly-Abused Drugs; Drugs Used in Psychiatry; Legal Terms; Neurologic Deficits; Psychologic Tests; Research Terms; and Schools of Psychiatry.

The text is available for \$5.95 a copy from the Publications Sales Office, APA, 1700 W. 18th Street, N.W., Washington, D.C. 20009. (Orders less than \$35 must be prepaid.) Quantity discounts are available. A hardcover edition may be ordered from Little, Brown and Co. for \$9.95 a copy (200 West Street, Waltham, MA, 02154, order No. 036-560).

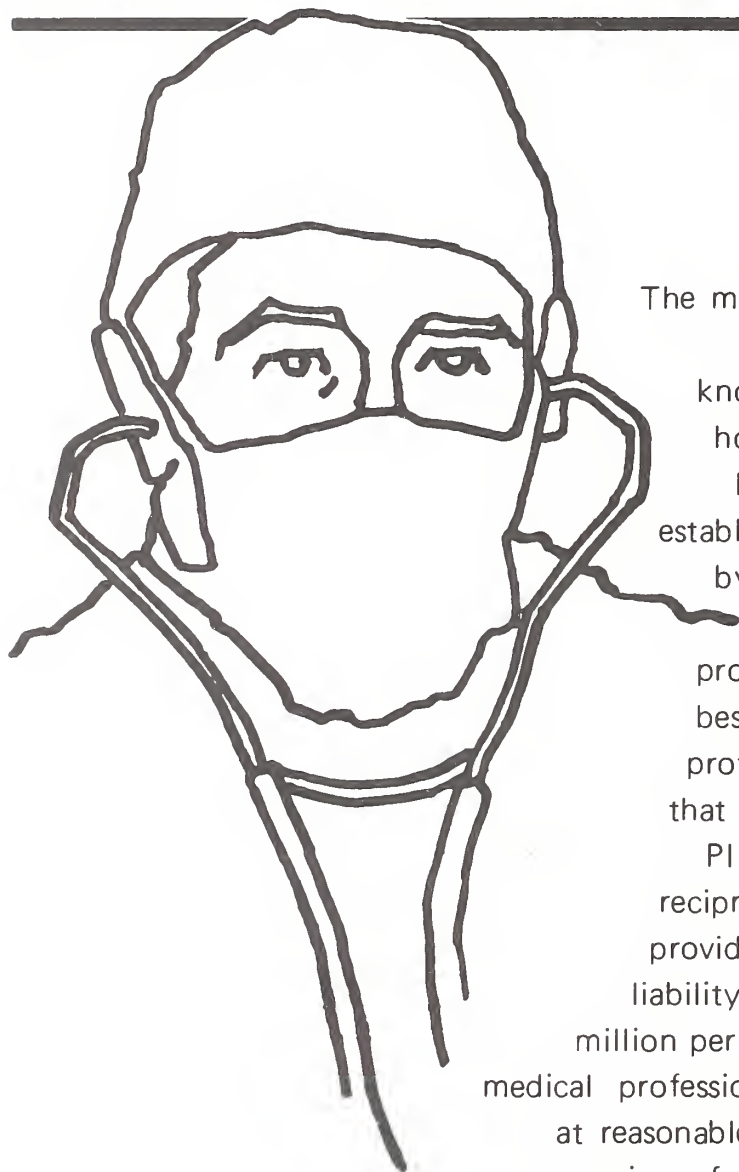
Clinical Aspects of Malpractice

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Several hundred patient case histories where malpractice was threatened, initiated, settled or tried have been carefully analyzed by the author as to the cause of the complaint that led to the malpractice action as well as pitfalls that might have been avoided. Case reviews, arranged by anatomical area, are presented from the physician's perspective, emphasizing the responsibilities the physician assumed in diagnosis and treatment. Additional chapters give practical advice on physicians' responsibilities and courtroom conduct.

The text is 224 pages, and is available for \$18.95 a copy (plus \$1 handling charge). Payment should accompany orders to Medical Economics Books (2309-DPRCO), Box 157, Florence, KY, 41042.

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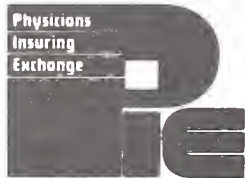
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FTC RE-FUNDED

The Federal Trade Commission (FTC) was closed in May -- but only for a day. The agency's temporary funding resolution expired on April 31. Late in the day on May 1, Congress passed, one last time, an additional month's funding for the FTC, which had been operating under temporary authorizations for two years. This last resolution provided the FTC with \$7.6 million for the month of May.

Meanwhile, the House-Senate Conference Committee on the FTC re-authorization finally agreed on a three-year budgetary authorization for the agency. The agreed bill, HR 2313, came after President Carter, at a meeting with senior members of the Committee, indicated that he would not veto a bill that contained a two-House veto of FTC industry wide regulations.

Congress approved the substitute bill, which does contain a two-House veto provision, near the end of May. The bill, the "Federal Trade Commission Improvements Act of 1980," extends budgetary authorizations for the FTC through September, 1982.

The two-House veto in the substitute bill is a compromise between House and Senate versions. The House version, supported by the OSMA, required only a majority vote of one House to veto an FTC industry wide regulation. The Senate version required the President to sign a veto resolution adopted by both Houses. Under the compromise bill the President has no role in Congressional vetoes of FTC regulations.

The compromise authorization bill places restrictions on the FTC's rule-making authority, enforcement proceedings, confidentiality of investigatory information received by the FTC, and activities with respect to a number of pending rule-making proceedings and investigations. Among the pending activities which are restricted by the compromise are

funeral industry rule-making, regulation of children's advertising, investigations of the insurance industry, and certain trademark challenges. All industry wide regulations by the FTC will be automatically submitted to Congress for review.

The delays and the debate over the authorization bill are evidence of substantial disillusionment with the FTC on Capitol Hill, where many law makers claim that the agency has acted beyond statutory authority, particularly with respect to business and the professions. Earlier this year, the Senate failed by only two votes to approve an exemption from FTC jurisdiction for the medical, legal, dental, veterinary, and other health professions.

HEALTH MANPOWER BILLS APPROVED BY COMMITTEE

The House Interstate and Foreign Commerce Committee adopted by voice vote two important health manpower measures, HR 7203 and HR 7204.

HR 7203 continues for three years Federal funding of education programs for nursing and the health professions, including the National Health Service Corps. Nursing education programs were not increased, but rather were authorized at current appropriations levels. Institutional support for hospital-based diploma nursing schools was continued. HR 7203 now awaits scheduling for House floor action.

HR 7204 extends for three years the "substantial disruption" waiver for foreign medical graduates. This waiver permits the continuation practice by foreign medical graduates in certain hospitals which can demonstrate a substantial disruption of medical services in the event of departure of foreign medical graduates. The bill also increases to seven years the length of time foreign medical graduates may stay in the U.S. for education. HR 7204

must next be cleared by the House Judiciary Committee.

MEDICARE/MEDICAID AMENDMENTS

Two committees with jurisdiction have approved a Medicare/Medicaid package of two bills, HR 3990 and HR 4000. Both bills have been adopted by the Interstate and Foreign Commerce Committee and the Ways and Means Committee. However, the committees approved different versions of each bill. These differences must be either resolved within the Rules Committee or fought out on the House floor.

One difference in the two versions of HR 4000 relates to quality assurance standards for laboratories. The Ways and Means version of the bill mandates the Department of Health, Education, and Welfare (now the Department of Health and Human Services) to develop and apply new quality assurance standards. This new mandate was deleted by the Commerce Committee, which substituted quality assurance guidelines used under current programs.

Both versions of HR 3990 continue the special 100% reimbursement of radiologists and pathologists accepting assignment on all services for hospital inpatients, and allow for pre-admission diagnostic testing by the outpatient department of a hospital within seven days of an admission to the same hospital. In addition, both versions permit some latitude in the application of Medicare standards to rural hospitals.

STATE

CONTROVERSIAL CALIFORNIA NURSING RULE

A forum at last month's OSMA Annual Meeting, "Medicine and Nursing -- Can We Work Together?" provided clear indication of the current

difficulty in delineating the separate roles and responsibilities of physicians and nurses in patient care. A new California regulation further blurs professional distinctions. The regulation permits registered nurses (R.N.'s) and physician's assistants (P.A.'s) to undertake certain procedures that previously could be performed only by physicians.

The new rules permit hospitals to allow R.N.'s and P.A.'s to perform certain "standardized procedures," such as starting I.V.'s, taking patient histories, conducting physical examinations, and, in some cases, writing prescriptions and ordering laboratory and X-ray services. "Interdisciplinary committees" must be established in any hospitals that allow these paraprofessionals to assume the expanded role. The committees are to oversee R.N. and P.A. performance.

These new rules, adopted by the California Department of Health Services, were opposed by the California Medical Association and the California Hospital Association. The Department defended the rules by stating that they permit nothing more than was already permitted in the practice acts of R.N.'s and P.A.'s and that the rules were developed because the practice statutes conflicted with licensing regulations.

PHYSICAL THERAPISTS RENEW LEGISLATIVE INITIATIVE

The Ohio Chapter of the American Physical Therapy Association is renewing efforts on a legislative program that could result in the elimination of physician and hospital involvement in the prescription and/or provision of physical therapy services. Two physical therapy bills, House Bill 210 and House Bill 211 are already before a subcommittee of the House Small Business and General Business Committee. Subcommittee hearings are scheduled on HB 211, a bill that permits physical therapists to form professional corporations.

During the last session of the Ohio General Assembly (1977-1978) the physical therapists were successful in establishing their own licensing board. At that time the OSMA opposed one severing oversight of the practice of physical therapy from the State

Medical Board. The OSMA and members of the Ohio General Assembly understood that the concerns of physical therapists were adequately addressed in 1978 by enacted HB 209.

Nevertheless, in a breach from the good faith agreement of last session, the Ohio Chapter of the American Physical Therapy Association drafted several new bills. HB 211 (Brown D-Columbus) adds physical therapists to the list of "professionals" in the Ohio Revised Code, thereby allowing physical therapists to form professional corporations composed solely of licensed physical therapists. HB 210 requires hospitals to accept and review physical therapists' applications for staff membership and/or practice privileges.

The other parts of the proposed legislative package of the Ohio Chapter of the American Physical Therapy Association, not yet introduced, would (1) eliminate the requirement for a physical therapist to receive either a prescription or a referral from a physician, dentist, or a podiatrist prior to the initiation of physical therapy; (2) establish the physical therapist as a "provider" for all state services requiring physical therapy; and (3) require Blue Cross to reimburse physical therapists directly for their services.

The Ohio Chapter of the American Physical Therapy Association is strongly supporting HB 211. Opponents of this bill argue that the inclusion of physical therapy as a statutory "profession" would thereby prohibit hospitals and other health care corporations from employing physical therapists. Section 1701.03 of the Ohio Revised Code, states a corporation, such as a hospital, may be formed for any purpose "other than for carrying on the practice of any profession." Therefore, if physical therapists are a statutory "profession," the provision of services by physical therapists on salary with a hospital could constitute the "illegal practice of physical therapy."

In 1978 a group of physical therapists filed suit against several Ohio hospitals alleging the hospitals were engaged in the "illegal practice of physical therapy." However, Ohio Attorney General Opinion N. 80-004, delivered a major setback to this argument. The opinion stated that physical therapy licensing

requirements "do not operate to require that a physical therapist practice independent of an employment relationship." In addition, the opinion states that professional corporations may not be formed by physical therapists.

The leadership of the Ohio Chapter of the American Physical Therapy Association is apparently considering two alternatives to gain its objectives: (1) court action to litigate the Attorney General's Opinion, and (2) legislative action to change the physical therapy practice act. The association's activists have asked the more than 1,500 members of the association to contribute \$200 per member into a "Legal Fund" for the furtherance of its objectives.

Proponents of HB 211 claim that passage would then establish the need for HB 210. If hospitals could not employ physical therapists, the hospitals would have to (1) grant staff privileges to therapists and/or (2) contract with a professional corporation of physical therapists. The additional objectives, elimination of physician referral and direct third-party reimbursement of therapists, could follow after enactment of the first two bills.

Physicians must be concerned with the way these limited practitioners are attempting to expand their scope of practice. Many physical therapists question whether the ardent proponents of this legislative package represent their views, especially if they are on salary with hospitals or other providers. OSMA members should contact members of the House Small Business and General Business Committee to explain the consequences of passage of HB 211 and its long-range implications.

Members of the committee are: Rocco J. Colonna (Chairman, D-Brook Park), Sherrod Brown (Vice-Chairman, D-Mansfield), Larry H. Christman (D-Englewood), Dean Conley (D-Columbus), Otto Beatty (D-Columbus), Patrick A. Sweeney (D-Cleveland), John P. Wargo (D-Lisbon), Dale N. Van Vyven (R-Cincinnati), Claire M. Ball, Jr., (R-Athens), Robert E. Brown (R-Perrysburg), and Robert L. Corbin (R-Dayton). Mail should be addressed: The Honorable _____, State House, Columbus, Ohio 43215.



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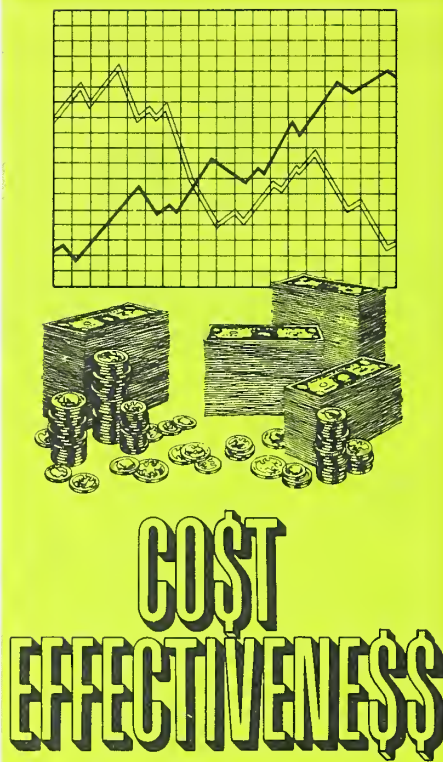
The Voluntary Effort for health care cost containment has been effective at the state as well as the national level in reducing health care costs while maintaining high quality medical care.

In 1976, the Toledo Area Chamber of Commerce felt these efforts should be supplemented with a local program that would provide a common forum for discussing problems regarding health care costs and therefore established an Ad Hoc Health Care Cost Committee. The committee consisted of representatives from business and industry, the Academy of Medicine of Toledo and Lucas County, and other local health care agencies.

Four subcommittees then were established. These committees were assigned separate areas of responsibility: cost containment, public information, special projects and physician's cost containment program. The committees helped to implement cost containment programs in hospitals, shared services and joint purchasing among area hospitals, and provided a communication link between reimbursement and health planning.

Although these programs played an important role in local cost containment, there was no liaison between business and industry and the health care system. Since business and industry provide a major part of the health insurance funds and purchase many health care services for their employees, it seemed appropriate that they become part of the cost containment effort.

In 1977, the Toledo Area Chamber of Commerce appointed a cost containment committee, held a cost containment seminar, and assisted in developing the Task Force on Cost Effectiveness, to coordinate local cost containment efforts with business and industry. Task Force representatives instituted a program to visit 14 local companies which represented a cross section of Toledo area employers. The purpose of these visitations was to develop a dialogue between business and industry and the health care system. The specific concerns that were



The Toledo Area Chamber of Commerce task force on health-care cost containment

By F. C. Henry, M.D.

raised from these visitations would be used in a seminar on cost containment the following fall.

The format used by the Task Force during these visits included a presentation by Task Force representatives regarding the national concern over health care cost, the increase in the nation's health care cost, cost per employee for health benefits, and increases in hospital charges in recent years. Factors which contributed to health care cost increases were discussed and included items such as inflation, energy, utilization of health care by the consumer, duplication of health services, new technology, and government regulation.

The cost containment efforts of the health care system also were discussed.

The hospital's role:

1. Sharing services.
2. Emphasizing outpatient care instead of inpatient care.
3. Increasing management efficiency.

The physician's role:

1. Reducing hospital length of stay.
2. Prudent use of diagnostic studies.
3. Increasing interest in preventative health care.

Health Planning Association activities:

1. Developing a regional health plan.
2. Facility planning.
3. Coordinating specialty services in health care.

Health insurance companies' activities:

1. Provide payment for alternatives to hospitalization such as preadmission testing, verticare, and outpatient surgery.
2. Public health education.
3. Coordination of cost containment activities with HPA, hospitals, and physicians.
4. Programs to provide second opinion for elective surgery.

Several areas promise to be quite effective in containing health care costs. These include reducing dependency of the consumer by encouraging self-care when

appropriate, educating the public in the appropriate utilization of the health care facilities and public preventative health programs using health education, life style modification, and accident prevention.

The Task Force recommended the following steps for health cost containment:

1. Designate a corporate staff member as a health care cost containment representative.
2. Support the local HSA.
3. Provide corporate liaison with representatives of the health care system.
4. Follow health legislation at the state and national level closely

and provide input to legislators when appropriate.

5. Examine and review employee health benefits on a regular basis.
6. Support preventative health programs, especially those regarding smoking, alcohol abuse, nutrition, accident prevention, and physical exercise programs.
7. Consider using health screening programs for employees.

The Chamber of Commerce sponsored a seminar on health care cost containment in the fall of 1978. Health planning, area hospitals, physicians, health insurers, and business and industry representatives discussed health care cost containment

from their respective points of view.

In 1979 the Task Force visited several additional Toledo companies and cosponsored a seminar on the national and local voluntary efforts on cost containment. Speakers for the seminar included the executive director of the national Voluntary Effort, the president of Blue Cross of America, and the president and chief executive officer of Kraft Foods.

The Task Force will continue in 1980 as an information and resource center for business and industry in the Toledo area for public information regarding health matters, health care cost containment programs, and health education for the community.



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An OSMA Interview

Editor's Note: Concern is rising among physicians as to the legal and practical considerations regarding the maintenance and use of physicians' medical records. This concern stems from the ever-present potential for malpractice claims and litigation and the protection of physician-patient confidentiality. The following interview with James E. Polilman, J.D., General Counsel for the OSMA and a partner in the Columbus law firm of Porter, Wright, Morris and Arthur, discusses some of these concerns and what steps physicians should be taking as to record maintenance and use.

OSMA JOURNAL: Are physicians legally required to keep records on patients for a specific number of years?

JAMES E. POHLMAN, J.D.: Generally speaking, no, there is no legal requirement to keep records for a specific period of time. However, good practice and good defensive medicine require that physicians keep records for a definite period of time.

JOURNAL: How long a period of time do you recommend?

POHLMAN: Except for the situation of prescribing controlled substances which by statute must be kept for two years, there is no other specific statutory requirement to retain records. However, there are a number of legal considerations involved in a decision by a doctor as to how long he keeps medical records, the most important being the statute of limitations for the assertion of malpractice claims against a physician. We normally counsel physicians who are clients of our office to maintain records on patients who are no longer being seen actively, for six to ten years.

There are, however, exceptions to the rule, and they occur in two instances. The first is the treatment of minor patients. Because the statute of limitations for malpractice claims by or on behalf of minors can be asserted anytime until the minor is 14 years of age, those physicians who see minor patients should be prepared to keep those records until the patient is 14 years old. There is another exception, and that's when a physician treats a patient with a Workers' Compensation claim. Even if the claim has been closed, the Bureau of Workers'

On Record

By Rebecca J. Doll

Compensation has the authority to modify awards at anytime for 10 years, so it's a good idea to maintain records on patients who have Workers' Compensation claims for at least 10 years after the physician-patient relationship is terminated.

JOURNAL: How long should a physician keep his records after he retires?

POHLMAN: We recommend that they be kept two years after retirement.

JOURNAL: How long should records be kept by the family after a physician dies?

POHLMAN: Again, there is no legal requirement, but we recommend two years.

The personal representative of the deceased physician also should make arrangements for the patients to be seen by other physicians in the community. Often a formal arrangement may be made for another physician or group of physicians to take over those patients and the records will be transferred as part of the transfer of practice. Where no specific arrangements have been made and the patients are dispersed among many physicians in the community, the family or personal representative should keep the records for two years, which will give the patient an adequate opportunity to have those records transferred to another physician. It also allows the estate to maintain the records in the event a malpractice claim may be brought against the physician after his death.

JOURNAL: What should be done with medical records if a physician decides to terminate a relationship with a patient?



James E. Pohlman, Esq.

"In some cases, well-kept records in and of themselves may be sufficient to defeat a nonmeritorious claim."

termination. He should document the time at which the patient was given notice of the proposed termination and the length of time during which the treatment was continued while the patient was given time to seek other care.

JOURNAL: We're hearing a lot about confidentiality of patient records and the fear on the part of patients and physicians that medical records could end up in the wrong hands. Are there any statutes which would allow medical records to be viewed by someone other than the physician?

POHLMAN: The confidentiality of records which a physician generates in the course of his patient-physician relationship arises from an Ohio statute which expressly recognizes physician-patient privilege. That privilege is for the benefit of the patient, but the patient may waive that privilege and request third parties, such as his or her lawyers, to inspect those records. Also, there are instances where other third parties have access by law to those records, such as Medicare which has a right of access to those portions of the record related to charges for certain care and treatments.

JOURNAL: Do patients have a legal right to gain access to their own medical records?

POHLMAN: Yes, a patient or the patient's representative, which usually is a lawyer, has a right to inspect and copy the records that are generated by the physician. There is an exception to that general rule and that is in the instance where a physician, in the exercise of his medical judgment, believes that disclosure of information contained in the record has a substantial risk of harm to the patient. In those cases, the physician may properly withhold the record from the patient or the patient's representative. This usually happens only in psychiatric care cases. The physician must, however, be prepared to defend the exercise of medical judgment and be able to show that a substantial risk of harm to the patient exists. There have been some cases which have been litigated over that issue.

JOURNAL: How long should a physician keep records on patients being seen actively?

POHLMAN: Our recommendation is that those records should be kept

permanently. If storage is a problem, microfilm can be used. But I believe it is prudent to keep all records on active patients.

JOURNAL: Is there ever an instance in which a physician should not put something on a record or should delete something from the record?

POHLMAN: In terms of the care rendered, it is important that the records be complete, that every diagnosis, every treatment, and all prescriptions be documented. It's never prudent to make an alteration in a record or delete anything after it has been placed in the record.

JOURNAL: What should a physician include in his medical records?

POHLMAN: Ideally, a physician's medical records should document every test, each diagnosis, and every treatment performed. The reason is that records serve several vital functions, legally, for the doctor. They serve first and foremost as a memory aid when he is called upon months or years later to tell what happened in a specific situation. The second function of records is to serve as an independent source of evidence of what in fact happened. For these reasons, physicians should be very careful when completing records. Vague or illegible notes should be avoided and care should be taken to be objective in the statements which are made in the record. These records may ultimately be made available to the lawyer of the patient if a claim should develop. That's not to say opinions should not be included in the records, but those opinions should be arrived at carefully by the physician and he should be prepared to defend those opinions if he is later called upon to do so in a court proceeding.

JOURNAL: Careful record keeping, then, is an extremely important function in the practice of medicine.


POHLMAN: Careful record keeping allows the physician an incomparable opportunity not only to practice good medicine but also to create the basis for his own defense in any subsequent malpractice litigation. In some cases, well-kept records in and of themselves may be sufficient to defeat a nonmeritorious claim. In nearly all cases, they will be of invaluable assistance in the preparation of a thorough and complete defense.

Mid-Ohio Race Physicians



A microcosm of applied emergency medicine

*By Charles B. Payne, Jr., M.D.
Richard E. Nensel, M.D.
Joseph C. Barkey, M.D.*



Automobile racing at Ohio's major professional road racing course can create a gamut of medical emergencies to participants and spectators alike. On hand to provide whatever emergency care may be needed is a volunteer group of Ohio physicians and allied health-care personnel — known collectively as Mid-Ohio Race Physicians.

Automobile Race Medicine, as practiced by a group of Ohio physicians, requires continuing education and innovation in all aspects of emergency medicine. Mid-Ohio Race Physicians (MORP), a volunteer organization based at the Mid-Ohio Sports Car Course in Lexington, Ohio, provides emergency care both for racing participants and spectators at all scheduled automobile races.

Auto racing, now the fourth largest spectator sport in the United States, began at Mid-Ohio in 1962 when the track opened under the direction of Mr. Les Griebling. Regulations, published by sanctioning bodies such as the Sports Car Club of America simply have required that a physician be present for a race to be sanctioned.

Occasionally the physician also was an amateur race car driver.

The Mid-Ohio track includes 15 turns of varying degrees of difficulty and direction within 3.7 km (2.4 miles). It is impossible to see the entire course from a single vantage point. Drivers attain speeds greater than 288 kilometers per hour (180 mph) and brake to 64 kph (40 mph) for corners. Racing continues in fair and foul weather. More than 50,000 spectators with vehicles, stoves, pets, etc., endure Ohio summer humidity and temperature up to 38°C (100°F).

Potential hazards include severe multiple injuries to drivers, crew, and corner workers. Gasoline, campfires, and welding occasion thermal and ophthalmologic injuries. Man-made as

The Ohio State Medical Journal



Formula Fords take a turn at the Mid-Ohio Race track in Lexington, Ohio.

Charles B. Payne, Jr., M.D.



"The Mid-Ohio track includes 15 turns of varying degrees of difficulty and direction within 3.7 km (2.4 miles) . . . Drivers attain speeds greater than 288 kilometers per hour (180 mph) and brake to 64 kph (40 mph) for corners."

well as natural electrical sources are a threat. Mass casualties and crowd panic must be anticipated, in addition to all the coincidental catastrophies which can and do occur at large automotive spectator events. One major driver problem is heat exhaustion. At one race in August, 1978, the combination of 30C (86F) ambient temperature, 65% humidity, and closed *Gran Turismo* sedans resulted in the treatment of 18 drivers for varying degrees of heat exhaustion.

Doctor Joseph Barkey, a Formula Vee driver, along with Dr. Harry Killian, an Alfa-Romeo driver, manned the initial 1962 Mid-Ohio medical facility housed in a tent provided by the track. Physicians and nurses, recruited by word of mouth, donated trackside

services, rode the ambulances, and received box lunches, tickets, and motel rooms through the courtesy of the race course management and sanctioning organizations. The tent was replaced by a prefabricated, one-room building after several years.

A modern, well-equipped, trackside hospital was built in 1971. This air-conditioned facility is similar to a small emergency room with equipment such as cardiac monitors and defibrillators. Radio communication is maintained with track officials, ambulance and helicopter crews, and police and fire teams. Telephone links the facility with designated evacuation hospitals. An additional trackside communication network is operated by Lake Erie Communications, a

voluntary organization which also provides flagging, initial accident control, and race traffic control at various Ohio motor race courses.

A standardized format is used to coordinate the activities of physicians, nurses, paramedics, and emergency medical technicians (EMTs) while on track duty. Medical personnel, along with communications, fire, and wrecking crews, are assigned to various potential crash sites. Oxygen therapy and personnel trained in advanced cardiopulmonary resuscitation, including intubation, and trained in technics of extraction of drivers from vehicles, are never more than one minute away from crash victims. Intravenous and oral fluid therapy, Heimlich valve, and chest



Richard E. Neusel, M.D., a member of the Mid-Ohio Race Physician team, track-side.

(Photo courtesy of Dr. Neusel)



The wide age-range of spectators prove the need for a variety of medical skills.



Charles B. Payne, Jr., M.D.

Handling a major trauma case in the track hospital.

Richard E. Neusel, M.D.

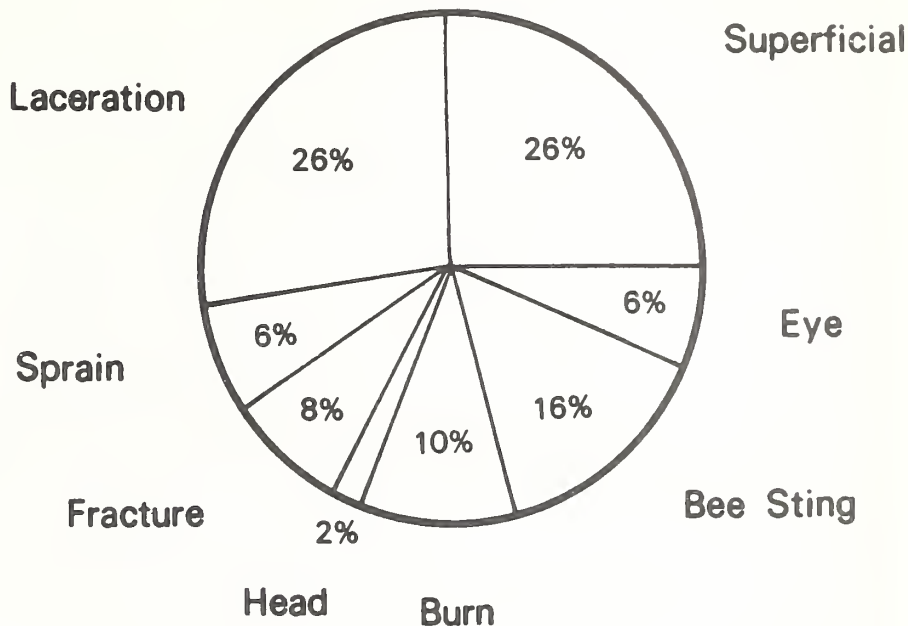


Mid-Ohio Race Physicians.
(Photo courtesy of Dr. Payne)



The Ohio State Medical Journal

“Mass casualties and crowd panic must be anticipated, in addition to all the coincidental catastrophies which can and do occur at large automotive sporting events.”



Percentages and types of spectator injuries seen at Mid-Ohio Race Course during three years (1974-1976), based on 50 randomly sampled visits during each year.



tubes can be placed, when necessary. Several modern ambulances are available immediately, and helicopter evacuation is possible, when indicated. A rehearsed disaster plan is operational.

Since 1962, two fatalities have occurred in races. Both were investigated and judged to be medically nonpreventable. Considering the number of practice and competitive miles driven, the track is a safer place to drive than the interstate highway system.

Using the facilities of the Commission on Professional and Hospital Activities (CPHA), a retrospective computer analysis of all treatment records from 1974 to 1976 was conducted. The results allow reasonable prediction of types of medical incidents involving spectators (see figure) and racing participants.

For the past eight years, MORP has sponsored an Annual Race Medicine June 1980

Symposium. This one-day meeting continues to attract international attendance and brings together various disciplines involved in improving racing and automobile safety.

The authors, active charter members of MORP, note that providing this degree of sophistication in automobile racing medicine involves: (1) a major interest in the sport of motor racing; (2) a race course management willing to cooperate with reasonable programs and dedicated to safety and improvement of the sport; (3) concentration of planning, work, and resources at a single medical facility; (4) willingness of volunteer professionals and paraprofessionals to cooperate to achieve a common goal using individual strengths without conflict; and (5) ingenuity in attracting sponsorship, equipment, and participants.

Since 1962, a variety of physicians have contributed to MORP. Some leave

and return, knowing they always are welcome. Specialists, including anesthesiologists, pathologists, obstetricians, psychiatrists, internists, surgeons, and pediatricians all have donated time to the service of motor racing in both rain and sun. Many have learned new skills and refurbished old ones. Each has enjoyed participating in MORP.

-
- Dr. Payne, Dayton, Staff Member, Veterans Administration Medical Center and Good Samaritan Hospital; and Associate Professor of Medicine and Director, Group in Pulmonary Medicine, Wright State University School of Medicine.
- Dr. Nensel, Toledo, Staff Member, Clinical Pathologist and Laboratory Hematologist and Director, Laboratory Hematology, The Toledo Hospital; and Assistant Clinical Professor, Department of Pathology, Medical College of Ohio.
- Dr. Barkey, Findlay, Staff Member, Blanchard Valley Hospital.
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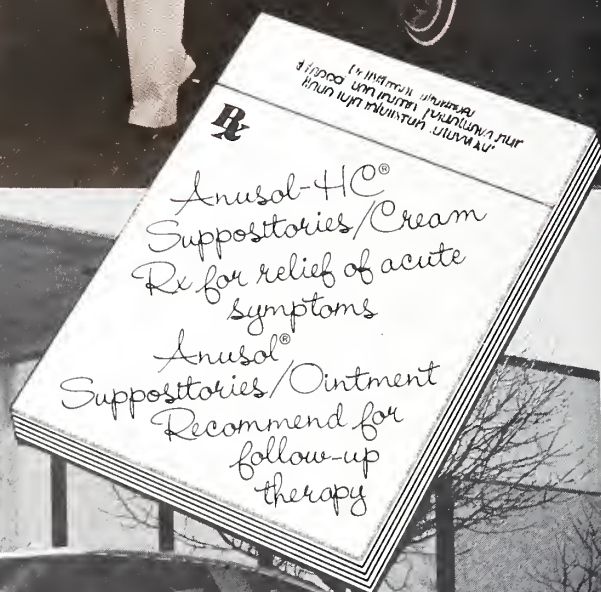
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CONSUMERS GUIDE TO MEDICAL CARE



Academy of Medicine of Cincinnati

The Cincinnati gamble

By Karen S. Edwards

The Clear Creek Valley Medical Society of Colorado had just discovered that when it came to physician directories, consumers weren't about to put their money where their mouth was. Meanwhile, in Ohio, the Academy of Medicine of Cincinnati was gambling that Cincinnati consumers would be more receptive than their Colorado counterparts. Would their gamble pay off?

On Monday, November 19, 1979, the Academy of Medicine of Cincinnati received 5,000 copies of their slick, 120-page "Consumers Guide to Medical Care," which had been nearly a year in the making. If Academy staff members and members of the society's public relations committee seemed a bit nervous as the wall of cardboard boxes containing the books grew higher and higher, they had good reason.

Just one year earlier, an article by Kathryn Jackson Fallon appeared in the November 13, 1978 issue of *Medical Economics* — an article ominously entitled, "For Sale: 3,500 Physician Directories — Cheap." The article

reported the "financial fiasco" that occurred when the Clear Creek Valley Medical Society of Colorado attempted to meet what it believed were consumer demands for a directory of local physicians.

According to the article, more than 150 hours of physician time was donated to compiling questionnaires that had been sent to all practicing MDs and DOs in the Northwestern Denver metropolitan area. The resulting 200-page volume went on sale to consumers at \$2.50 each — a sum that would allow the medical society to recover its expenses. What happened, however, was the "financial fiasco"

already described.

William I. Doig, M.D., society past president, stated in the article that, "We figured that if we sold 4,000 copies we'd break even. Instead, we sold about 1,500 directories and suffered a \$7,000 loss."

Even more discouraging for the Colorado Medical Society was the fact that most of the directories that were sold went to physicians and medical societies that had heard about the project, but few to the consumers for whom they were intended.

"They just didn't want it," the article quoted Joel Karlin, M.D., who was in charge of the project, as saying.

Despite adequate publicity on the directories, the public just wasn't buying.

"I have a feeling that a small number of people in a community make a lot of noise about consumer advocacy, but that the average person isn't concerned," Dr. Karlin was quoted.

The lesson has apparently been a hard one to learn.

The article mentions that several other medical societies in the country have come out with similar physician directories, and all have faced the same lack of consumer demand.

"The only way I could possibly see anyone successfully putting out a directory in the future would be in conjunction with an ad agency," Dr. Karlin is quoted as saying, but he adds, "We didn't do this because we thought that having advertising in the directory would be unprofessional and perhaps even unethical."

The article ends on a discouraging note, with a quote from Karlin, "I wish anybody who takes on such an endeavor good luck. They'll need it."

With the Clear Creek Valley Medical Society of Colorado painting such a dismal picture of the public's need for a physician directory, it seems incredible

A TYPICAL LISTING IN THE CINCINNATI ACADEMY'S "CONSUMERS GUIDE":

John Smith, M.D.

700 Provident Bank
7th and Vine Sts. 45202
555-2590

Specialty: Gynecology

Subspecialty/Interest: Abdominal
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Medical school: University of
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Internship: Deaconess Hospital

Residency: Deaconess Hospital
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referral; does not make house calls;
no age limit for patients; speaks
French; will discuss fees with
patients; does see some public
assistance patients.



Cincinnati Academy staff members: l. to r. Dianne Bricker, Pamela Fairbanks, William J. Galligan and Donna Gilliam.

that just one year later, the Academy of Medicine of Cincinnati (with what can only be described as Cincinnati chutzpah) was sitting on top of 5,000 copies of their own physician directories. There was, however, one big difference. All 5,000 copies of the Cincinnati directory were already paid for.

"The public relations committee considered costs very early in the planning stages of its directory," said Dianne Bricker, Director of Communications for the Academy of Medicine of Cincinnati — and true to Dr. Karlin's statement, Bricker admits that the selling of advertising space had been discussed.

But, while the idea for the project — and its cost — was still germinating in committee, Academy Executive Director, William J. Galligan and Arnold Leff, M.D., who was then Commissioner of the Cincinnati Board of Health, discussed the possible funding of the project by the Board of Health.

"Dr. Leff was a consumer-oriented Commissioner," Galligan recalls, and the idea of a consumer guide to physicians must have appealed to him. The Academy was notified that their book would be funded by the Board of Health.

This was the green light the public relations committee needed. Committee members selected areas of information which they felt should be included in the directory, then Academy staff members mailed out questionnaires requesting information

in these areas from their membership — over 1,300 strong.

An overwhelming 1,100 physicians responded with the information they requested. Staff members Donna Gilliam and Pamela Fairbanks then took over the gargantuan task of reviewing, standardizing, and cross-referencing information so that everything printed would not only be accurate, but fair to all responding physicians. The job took hours and hours of staff time, but at last, final drafts were written and approved and sent to a printer. The result was the 5,000 copies of "Consumers Guide to Medical Care," packed neatly away in cardboard boxes.

While there was no real financial gamble at stake for the Cincinnati Academy, there was still face to be saved. After all, the Academy couldn't guarantee (especially in light of the Clear Creek Valley failure) that the Board hadn't bought a "pig in a poke" — a book that couldn't even be given away. (The Academy had decided not to charge for its funded guide.)

As a precautionary measure against uninterested consumers, the communications department assembled a distribution list that would ensure, at least, that most directories would leave the office. Copies were sent to each Academy member (who participated or not) to health-care providers; a healthy 1,000 copies to the supporting Board of Health; more copies to large companies for employee distribution; and to countless media personnel, who were, at the same time, invited to a special

Urdu spoken here . . .

press conference on the guide.

Such precautions proved to be unnecessary. Word of the free directories spread quickly, and requests poured into the Academy office from those very consumers who had proven to be such an elusive bunch in Colorado.

By Friday, November 23, just four days after that wall of cardboard boxes had appeared in the Academy of Medicine of Cincinnati's office, the supply of consumers guides had been all but exhausted.

On December 4, Bricker issued a memo to Robert J. Hasl, M.D., Chairman of the Public Relations Committee, which said:

"Obviously, the community has responded overwhelmingly to this public service project. You deserve to be quite proud. The requests for copies of the publication continue. In fact, we estimate that the Academy of Medicine could easily distribute an additional 10,000 copies of the Consumers Guide to Medical Care by this time next year. . ."

Meanwhile, Bricker was issuing news releases that notified the public copies of the guide were no longer available.

Consumers, however, were turning a deaf ear to Bricker's "empty-hands" publicity, and the Academy saw that a reprint of the guide would have to be made quickly in order to meet the dozens of requests that came into their office almost daily.

Two companies were contacted by the Academy for reprint funds, and Merrell National Laboratories was the firm that agreed to come up with the money for additional copies. Five thousand books were again ordered, and again were exhausted in a short time.

"We will probably publish again in early 1981," Galligan commented, adding that the new book will be updated and expanded to include first-aid information, as well as other health-care information that will be of pertinent interest to consumers.

"We will seek funding again*," Galligan says, and commented that other avenues of revenue-seeking are being explored. "We're tossing around

Cincinnati patients who are in need of a physician speaking Urdu (or any one of 50 common and not so common languages); a physician who will make house calls or one who has evening office hours, need only turn to the Cincinnati Academy of Medicine's "Consumer Guide to Medical Care" to find the answers they're looking for.

The "Consumers Guide" is the result of efforts made by both the Academy's Public Relations Committee and Academy staff to provide the public with a way to make a more informed choice of a physician. Said Committee chairman, Robert Hasl, M.D., in an article in *Cincinnati Medicine*: "We want the public to realize that the Academy of Medicine is much more than simply doctors joining together for the benefit of doctors. We exist to help promote programs for the betterment of the patient."

The Guide is divided into three sections to serve the consumer. The first section provides general information about how to be a better,

more aware patient. Topics include how to select a physician, what is a true medical emergency, and the public's responsibilities as a patient. Section two includes specific information about the physicians, such as office location, specialty, education, accessibility to the office by the handicapped, and billing policies. The third section is a cross index of physicians by specialty, office location, and foreign languages spoken.

Fees are not included in any listing. Besides the fact that the FTC could construe the publishing of such information as price fixing, Dr. Hasl remarks, "We do not believe that the quality of care offered by two physicians can be compared simply by comparing fees."

As one of only a few such publications in the country, the "Consumers Guide" reflects the public's right to have information, as well as the physicians' right to insist that information be presented as accurately as possible.



Robert Hasl,
M.D.

the possibility of letting hospitals and companies who order large quantities of the book for employee and patient distribution pay for their own issues. We could let them have several pages in the guide for their own use — for their own message to consumers. That way, they would be more involved in the book — and perhaps more willing to pay."

Although this idea may border on the concept of advertising, those books that would carry the message of institutions and companies would not be distributed on a general basis. Instead, the books would be delivered to the sponsoring hospital, which would then distribute them internally, limiting the books' circulation to people

who will find the "message" applicable.

Will consumer demand for the guide continue to be as strong in the future? The Academy is wrestling with that question now.

"We think we will be publishing the guide every other year," Bricker says. "My one regret is that we didn't include response cards in the first guides that would enable readers to let us know if they would want future, updated issues, or whether one is enough."

It's the same with any gamble, though. Win or lose, there's always another risk right there . . . waiting for you.

*The local health systems agency, CORVA, has promised to underwrite a third printing of the guide for 5,000 additional copies.



"Organized medicine is the only method we have to combat government's attempts to regulate us."

Robert G. Thomas, M.D.; *A Presidential profile*

By Rebecca J. Doll

OSMA's newly installed president thinks his year in office will be a high flying experience. Literally.

As a pilot who flies both airplanes and helicopters, Robert G. Thomas, M.D., an Elyria pathologist, spends much of his time commuting by air to Columbus to attend the many meetings required of his work with the OSMA and Physicians Insurance Company of Ohio (PICO). Not only does it save him time, it is fast becoming as inexpensive as travel by automobile.

Dr. Thomas, whose term in office began with his installation during OSMA's Annual Meeting May 14, uses the efficiency of air travel in his practice of medicine. He and his associates provide laboratory and pathology services to six small community hospitals in Northeastern Ohio which cover a radius of several hundred miles.

"These hospitals are so small they cannot afford the services of a pathologist nor the equipment necessary to offer a large range of laboratory services," he explains. "By using the helicopter, we can provide services to these hospitals at less expense than it would take to hire a pathologist and purchase the equipment."

In his remarks to the OSMA House of Delegates, Dr. Thomas did not set forth any specific goals for his term of office. Too often, he says, predetermined goals must be shoved aside when an unforeseen situation arises requiring immediate action.

"I don't think it's realistic to set goals and expect to accomplish them in one short year. I think our activities as an association and consequently, our goals, will be determined by the social environment we'll be living in."

He does believe, however, that the biggest problem facing medicine today is government encroachment into the

The Ohio State Medical Journal

decision-making aspects of medicine.

"Government's attempt to make medical decisions is a dangerous precedent. And we're seeing this encroachment not just in medicine but in freedom of the press, the marketplace and many other areas," he says, adding that the real danger lies with the fact that government has much less ability to govern than it would have us believe. He cites the current economic situation as an example of government which believes that to solve economic and social problems, government control and regulation is necessary.

As gloomy as the situation may seem, Dr. Thomas believes that people are finally beginning to recognize the danger and are calling on their elected representatives to stop government encroachment into their private lives.

"We have to recognize that we, meaning various special interest groups, brought a lot of the problems on ourselves by turning to government to seek personal advantage. Now it's up to us to realize that we have to regain control of our own lives and

stop turning to government to help us out."

That's why associations such as the OSMA are very important, he says, because they offer an organized attempt at solving our own problems. He cites as an example the creation of PICO.

"Organized medicine is the only method we have to combat government's attempts to regulate us. That's why I am constantly amazed at the apathy many of our members show and even more amazed at those who don't join, claiming that organized medicine doesn't represent them.

"I am always surprised that when we have a major problem, so few respond to the call for help. Yet somehow we've managed to be fairly successful. Imagine how successful our programs would be if we received more help from members."

According to Dr. Thomas, many physicians are becoming paranoid about the problems facing medicine.

"There actually are physicians who really believe there is some sort of organized conspiracy against medicine. I suspect that's not true at all. People

who want to do this do so from lack of information. That's why we need more physicians involved in the activities of organized medicine. We need more people speaking to local community groups, to the local media, and the legislature," he stresses.

"I believe very strongly that decisions concerning medical matters must be made by physicians. This includes health planning. To have HSAs (health systems agencies) dominated by consumers is absurd. Decisions should be made by those with medical knowledge, not legislators or individuals with no medical background."

Dr. Thomas believes that rising health care costs is another area which needs the attention of physicians, but not in the form of cost cutting.

"We hear a lot of talk about rising health care costs and that we are spending almost 10 percent of our gross national product on health in this country. I can't see anything wrong with that if it translates into better, healthier, happier lives. There are worse ways to spend a tax dollar."

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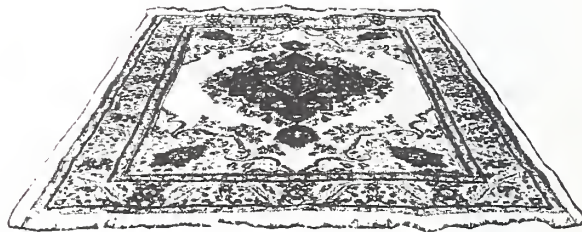
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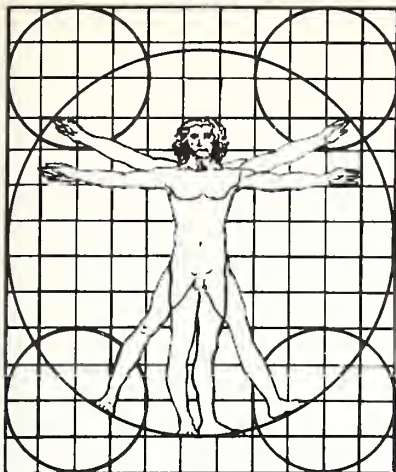
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CLINICAL & SCIENTIFIC

The Control of Smoking: The Physician's Role

Saul R. Kelson, M.D.
James L. Pullella, M.P.H.
Gere B. Fulton, Ph.D.

Surveys in 1964 and 1971 of Toledo, Ohio area public school students showed increased smoking in 1971 by boys and girls in every grade. Higher percentages of boys smoked both years in all grades except 8 and 9 in 1971. A 1976 survey showed further increases in the percentages of girl smokers — exceeding boys in every grade except 12. The percentages of boys who smoked increased over 1971 in grades 7, 8, and 9, but decreased in 10, 11, and 12. Evidence indicates the predominant antismoking influence of physicians. But they can do more. Intensified antismoking education in medical and osteopathic school curricula is stressed, as is the formation of separate national, state, and local groups in the cancer, heart and lung organizations, or in interagency agencies, solely to spur antismoking efforts by physicians.

IN 1975, KELSON, PULLELLA, and Otterland¹ reported on two surveys of smoking habits and attitudes toward smoking among students in grades 7 through 12 in Toledo and Lucas County (Ohio) public schools. The first survey, in 1964, was based on questionnaires filled out by 25,131 students; the second, in 1971, by 29,682 students.

These surveys dealt with the prevalence of student smoking, the reasons for their smoking or not smoking

and for other students' smoking, the students' beliefs concerning the health hazards of smoking, the smoking habits of their parents, their views as to their parents' attitude toward their smoking, whether they smoked in the presence of their parents and, in the 1971 survey, their opinions concerning the influence of radio and television programs and commercials on their ideas about smoking.

A remarkable finding was a prevalence of student smoking justifying the title, *The Growing Epidemic*, for this initial report. From 1964 to 1971, smoking by boys and girls increased in every grade. Higher percentages of boys than girls were smokers in 1964 and 1971 in each grade, except in 1971 girls exceeded boys in grades 8 and 9.

A third, similar survey was conducted in 1976 on 19,891 Toledo and Lucas County public school students.* The figure presents the smoking habits of students in 1976, as well as 1964 and 1971. In 1976 there was a further increase in every grade in the percentage of girl smokers; this nearly doubled in grade 7 but increased little in grade 10. Note the striking increase in girl smokers in grade 7, from 3.6% in 1964 to 22.8% in 1976. The boys showed increases over 1971 in grades 7, 8, and 9, but decreases in grades 10, 11, and 12.

In 1976, girls exceeded boys in the percentage of smokers, not only in grades 8 and 9 as in 1971, but in every other grade surveyed, except grade 12. In 1964 the

Dr. Kelson, Toledo, Director, Veterans Administration Outpatient Clinic and Past Chairman of the Ohio Advisory Board on Smoking and Health.

Mr. Pullella, Toledo, Assistant Health Commissioner.

Dr. Fulton, Toledo, Professor of Health Education, The University of Toledo.

Reprint requests to Veterans Administration Outpatient Clinic, 3333 Glendale Avenue, Toledo, Ohio 43614 (Dr. Kelson).

Submitted November 7, 1979.

*A report of this 1976 survey, in conjunction with a similar survey projected for 1980, is planned for publication. An additional 6,708 city parochial students studied in 1976 will be the subject of a separate report, as compared with city and county public school students.

prevalence of smoking among girls was 59.0% of that among boys. In 1971 it increased to 85.7%, and in 1976 to 121.1%.

The students smoked despite the belief by the majority that smoking is harmful to health. A higher percentage of girls than boys held this belief, yet more girls smoked (Table 1). Acknowledging the health hazards of cigarettes was no deterrent to smokers, perhaps because the dangers lay too far in the future. But paradoxically, harm to health was the predominant reason checked by nonsmokers for not starting to smoke.

What can we do to stem this growing epidemic of smoking? Our report of the earlier surveys stressed beginning antismoking education early, and gaining the help, by example and precept, of the youth's peers, and of key adults such as parents, teachers, doctors, dentists, nurses, and athletic coaches.

The physician may well have the greatest influence on smoking by youths as well as adults.

A national study of teenagers, conducted in 1969 for the American Cancer Society by Lieberman Research, Inc.,² concluded that "Young people might resist beginning the cigarette habit, or could more easily stop it, if figures of authority and influence such as teachers and physicians set better examples and urged them not to smoke." A 1975 Public Health Service study³ indicated that of the physicians surveyed 91% believed it their responsibility to set a good example by not smoking, and 74% to convince people to stop smoking.

A great number of physicians have set an excellent example by giving up smoking. As the well-known poster attests, "100,000 Doctors Have Quit Smoking Cigarettes." An American Cancer Society survey⁴ showed a decrease in physicians who smoked cigarettes from 38.6% in 1959 to 19.5% in 1972. The 1975 Public Health Service study

reported a fall in cigarette smokers among physicians from 30% in 1967 to 21% in 1975.³

All too often, however, physicians do not speak out emphatically to their patients. Smokers again and again relate that their physicians never have urged or told them to stop. "The trouble with doctors," it has been said, "is that they don't preach what they practice."

Of the nonsmokers among teenagers surveyed by the Lieberman Associates,² 72% said physicians were the one group that could persuade them not to start smoking. Of the smokers, 42% said that advice from a physician would influence them to stop. Yet a recent American Cancer Society study⁵ found that 73% of teenagers reported that their physicians never had warned them of the dangers of cigarette smoking!

In our 1976 survey students were asked to check if they *could* or *could not* "be persuaded to give up smoking." More than 85% indicated that they *could* be persuaded. Those who had so indicated were asked then to select the response that best expressed their feelings: "I could be persuaded to give up smoking if" — followed by six alternatives.

The statement, "My father, mother, or one of my grandparents died of a disease related to smoking," was checked by 10.4% of the boys and 16.3% of the girls who could be persuaded to give up smoking. "I developed a persistent cough or shortness of breath," was checked by 14.8% of the boys and 12.3% of the girls. But far ahead, with 56.4% of the boys and 49.9% of the girls, was: "I could be persuaded to give up smoking if: My doctor strongly urged me to do so." (See Table 2)

The work of Russell⁶ supports such views of the effectiveness of urging by a physician. He has found that of patients given "simple but firm advice" on a single occasion by their family doctors to stop smoking, 19%

SMOKING HABITS TOLEDO AND LUCAS COUNTY PUBLIC SCHOOL STUDENTS Grades 7 thru 12-1964, 1971 and 1976

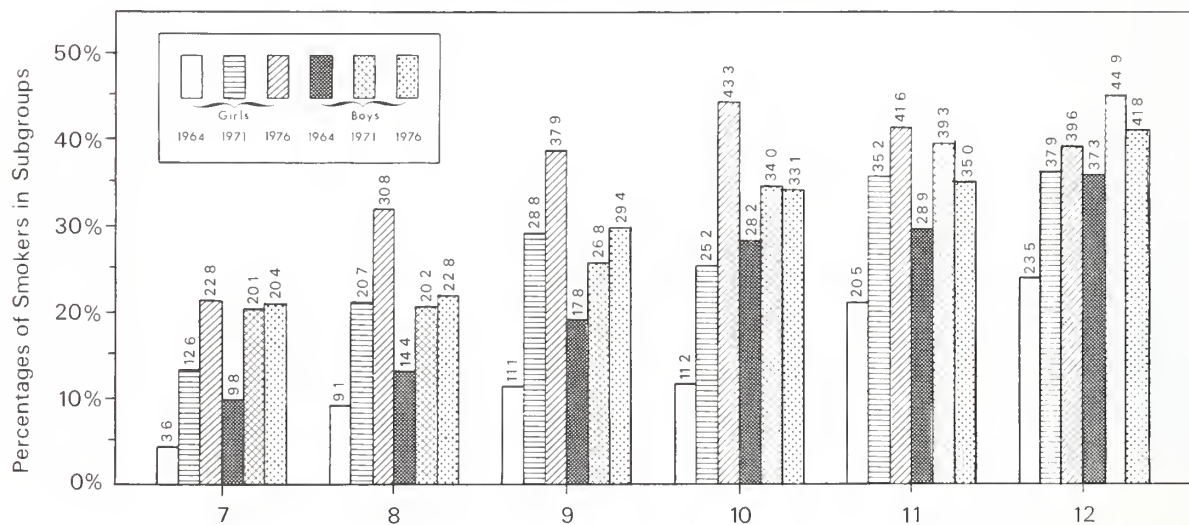


Table 1. Prevalence of Belief That Smoking is Harmful to Health, by Smoking Habit, Sex, and Grade

	Grades 7-9	Grades 10-12
Believe Smoking Is Harmful to Health		
<i>Smokers</i>		
Boys	1,011 (82.0)	1,428 (87.3)
Girls	1,399 (86.0)	1,837 (87.4)
<i>Nonsmokers</i>		
Boys	3,402 (89.2)	2,665 (92.1)
Girls	3,309 (92.2)	2,760 (93.4)
Subtotal	9,121 (88.9)	8,690 (90.6)
Do Not Believe Smoking Is Harmful to Health		
<i>Smokers</i>		
Boys	222 (18.0)	207 (12.7)
Girls	227 (14.0)	266 (12.6)
<i>Nonsmokers</i>		
Boys	414 (10.8)	229 (7.9)
Girls	281 (7.8)	195 (6.6)
Subtotal	1,144 (11.1)	897 (9.4)
TOTAL	10,265	9,587

had stopped at one year compared with 11% of controls given no such advice. "If all the 20,000 plus GPs in Britain," Russell adds, "were to persuade even one patient a week to stop smoking, the yield would be more than 1 million ex-smokers a year."

Why do physicians so often fail to exert their great authority and persuasiveness against smoking? How can an obstetrician possibly not impress his patients with the harm their smoking can exert on fetal development? How can a pediatrician fail to influence a young patient to give up his destructive habit? We have made no special study of this question, but our impression is that physicians are or feel they are too busy — as in their frequent neglect to teach vital breast self-examination to their women patients. (A Gallup survey conducted in 1973 for the American Cancer Society⁷ found that only 35% of all the women reported that a physician had ever brought up with them the topic of breast self-examination. Only 24% of all women had been instructed by a physician on how to do breast self-examination. Even among women seeing a gynecologist for periodic check-ups, only 34% had been instructed by a physician in breast self-examination.)

Of course, physicians know well the facts about the hazards of smoking, but not all are zealots and crusaders. They may assume, also, that with the air so full now of antismoking information and appeals, patients are fully

Table 2. Response to item "I could be persuaded to give up smoking . . ." by grade and sex for those who felt they could be persuaded

1976						
Response Categories	Grades 7-9		Grades 10-12		All Grades	
	Boys	Girls	Boys	Girls	Boys	Girls
At MD's strong urging	2,574(57.1)	2,269(48.2)	2,269(55.6)	2,368(51.6)	4,843(56.4)	4,637(49.9)
If parents would stop	435(9.7)	469(10.0)	291(7.1)	313(6.8)	726(8.5)	782(8.4)
If I developed persistent cough or shortness of breath	559(12.4)	503(10.7)	710(17.4)	641(14.0)	1,269(14.8)	1,144(12.3)
If my teachers were not smoking	47(1.0)	23(0.5)	51(1.2)	20(0.4)	98(1.1)	43(0.5)
If father, mother or grandparent died of smoking-related disease	503(11.2)	815(17.3)	393(9.6)	698(15.2)	896(10.4)	1,513(16.3)
If convinced that my appearance could improve	386(8.6)	625(13.3)	369(9.0)	550(12.0)	755(8.8)	1,175(12.6)
TOTAL	4,504(100.)	4,704(100.)	4,083(99.9)	4,590(100.)	8,587(100.)	9,294(100.)

informed and that further efforts are futile. They underestimate their own great influence.

How can we move physicians to vigorous antismoking efforts? It is not enough to press medical societies to pass resolutions (which often are soon forgotten) to recruit speakers on smoking for medical meetings, to publish articles in medical journals, to distribute antismoking pamphlets and posters to physicians' offices, to organize more conferences and workshops on smoking.

It is preferable to begin with the physician as student, with antismoking education occupying a prominent place in the medical and osteopathic school curricula, not only making clear the health hazards of smoking, but stressing the physician's role as exemplar and his responsibility to influence his patients against smoking. (An excellent American Cancer Society film can spur the physician's antismoking efforts. It is *The Physician's Role in the Control of Lung Cancer*: A.C.S. Code #3776, 1978.)

We would recommend setting up separate departments in the cancer, heart, and lung organizations or the national interagency group, concerned solely with galvanizing physicians into antismoking efforts, with separate committees in each state division and local unit to carry on persistent efforts with medical groups and individual physicians in their areas.

Such committees* will enlist more physicians in community antismoking campaigns. They will inform the physician of community resources that he can call on to assist him with his patients. Of particular importance, they will secure the vigorous help of certain influential physicians to work continually with their colleagues.

Others have indicated how the physician can direct his important antismoking efforts. Among the recommendations of the National Commission on Smoking and Public Policy of the American Cancer Society is:⁸ "Physicians should counsel patients on the risks of smoking and how to quit smoking or make referrals to various types of smoking cessation programs offered in the community." The Committee on Cigarette Smoking and Cardiovascular Diseases for Health Professionals of the American Heart Association⁹ recommends that: "Physicians should actively encourage the elimination of cigarette smoking by personal example and positive actions. Do not allow smoking in the physician's office by patients or nurses. Always raise the question of smoking in connection with vascular, pulmonary disease, and general health examinations. Locate and refer patients to smoking

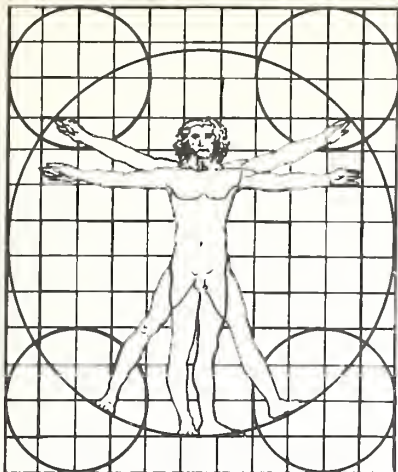
cessation clinics when necessary. Obtain help from the family in the smoking cessation endeavor. Check on compliance with advice periodically." A key objective of Target 5, the five-year antismoking program of the American Cancer Society is "... a commitment by every physician and dentist to confront every patient who smokes, at every consultation, on the dangers of smoking, and to encourage him to stop."¹⁰

Acknowledgements: The financial support of the Graduate School of the University of Toledo; American Heart Association, Northwestern Ohio Chapter, Inc.; Northwestern Ohio Lung Association; and particularly the American Cancer Society, Lucas County Unit. For their cooperation and assistance in the 1976 survey, we thank the Toledo and Lucas County schools; the Diocesan Catholic schools; the Toledo and Lucas County Health Departments; and Professor Mohan L. Garg and Mr. Werner Gliebe of the Department of Cost Containment and Evaluation, Medical College of Ohio at Toledo. We express special gratitude to Messrs. William Jacob, George Nimmo, and David Schafer.

References

1. Kelson SR, Pullella JL, Otterland A: The growing epidemic: A survey of smoking habits and attitudes toward smoking among students in grades 7 through 12 in Toledo and Lucas County (Ohio) public schools — 1964 and 1971. *Am J Public Health* 1975;65(9):923-938.
2. Teenage smoking, new ACS study shows young people's beliefs and behavior. *Cancer News* 1969-1970;23:3-7.
3. Smoking behavior and attitudes of physicians, dentists, nurses and pharmacists, 1975. Center for Disease Control. *Morbidity and Mortality Weekly Report* 1977;26(23):185.
4. Garfinkle L: Cigarette smoking among physicians and other health professionals, 1959-1972. *CA — A Cancer Journal for Clinicians* 1976;26(6):373-375.
5. *Teenage Boys and Girls and Cigarette Smoking*. A supplemental study. Prepared for the Education Department of the American Cancer Society by Yankelovich, Skelly and White, Inc., p. 19, Feb. 1976.
6. Russell MAH: *Smoking Problems: An Overview. Research on Smoking Behavior*. National Institute on Drug Abuse Research Monograph 17, U.S. Department of Health, Education, and Welfare, pp. 18 and 23, Dec. 1977.
7. *Women's Attitudes Regarding Breast Cancer*. A Gallup survey conducted for the American Cancer Society. Summary, pp. 6 and 7. The Gallup Organization, Inc., 53 Bank St., Princeton, N.J. 1973.
8. *A National Dilemma: Cigarette Smoking or the Health of Americans*. Report of the National Commission on smoking and public policy to the Board of Directors, American Cancer Society, Inc., 1978. New York: American Cancer Society, 1978.
9. *American Heart Association, Report of Ad Hoc Committee on Cigarette Smoking and Cardiovascular Diseases for Health Professionals, June 1, 1977*. Distributed by American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231.
10. *Task Force on Tobacco and Cancer. Target 5*. American Cancer Society, Inc. report to the Board of Directors, p. 15, 1976.

*A committee of physicians already has been formed in Toledo, with representatives from the Cancer Society, the Heart Association, the Lung Association, the Medical College of Ohio at Toledo, the Toledo Board of Health, the Academy of Medicine, and the Osteopathic Association, as well as the Toledo Dental Society.



CLINICAL & SCIENTIFIC

X-Ray Therapy, Thyroid Nodules and Thyroid Cancer

Jack M. George, M.D.

All patients who have been treated with external x-ray therapy to the head or neck, even many years ago, should have careful physical examination of the thyroid for possible nodules that may indicate thyroid cancer. Thyroid scan and echography are useful technics for evaluation of thyroid nodules in making a decision about thyroid surgery. Although the incidence of thyroid cancer after external irradiation is significant, there is no known increased incidence of thyroid cancer following radioiodine [¹³¹I] treatment of hyperthyroidism. With proper therapy, patients with the most common types of thyroid cancer have an excellent prognosis.

THYROID CANCER is fortunately uncommon and often can be cured by surgery and ¹³¹I therapy. Palpable abnormalities of the thyroid are common and the problem is to sort out from the large population of patients with a palpable thyroid nodule the small number who are at high risk for thyroid cancer and who should have surgery. Thyroid cancer as a late effect of childhood head and neck x-ray therapy (not diagnostic x-rays) has been in the news to a great degree.¹ There was a period of time when medical practitioners were using x-ray therapy to the neck of infants with respiratory difficulty, and what were thought to be enlarged thymus glands producing tracheal obstruction. We also have seen patients who had x-ray therapy for acne as teenagers and for treatment of enlarged tonsils and adenoids. It is necessary to evaluate for possible thyroid cancer any patient who has been treated with x-ray therapy to the head or neck. The most

important part of that evaluation is physical examination of the thyroid.

Physical Examination of the Thyroid

Although there are several methods of thyroid palpation, we prefer to have the patient seated with the physician standing behind. We locate the thyroid cartilage (Adam's apple) and the cricoid cartilage which is the next large cartilage inferior to the thyroid cartilage. The isthmus of the thyroid gland crosses the trachea just inferior to the cricoid cartilage. The two lobes of the thyroid are just lateral to the isthmus, although they may extend some distance superiorly or inferiorly. The patient is given a cup of water to sip so that when we have located the above landmarks and positioned our hands, the patient can swallow. The thyroid and anything attached to it always moves with swallowing. Any lump in the neck that does not move with swallowing is not thyroid; it may be a lymph node or some other structure. The thyroid lobes can extend somewhat far superiorly so that a nodule in either the right or left superior pole of the thyroid easily can be as high in the neck as the thyroid cartilage. Conversely, the thyroid can be so low-lying in the neck as to be almost entirely behind the sternum and can be palpated only when the patient swallows and it rises up under the examiner's fingers. If the patient has a thick neck, the examination of the thyroid can be very difficult.

The normal thyroid is symmetrical and barely palpable. Any asymmetry of the thyroid in a patient with a history of head or neck irradiation therapy should arouse the suspicion of thyroid cancer and lead to consideration of surgery for a tissue diagnosis. A thyroid nodule is defined as any localized enlargement of an area of the thyroid ranging from barely palpable, 1 cm in diameter or less, to involvement of most of one thyroid lobe, several cm in diameter. Once a nodule has been found in one lobe of the thyroid, it is important to determine whether the thyroid lobe on the other side of the trachea also is

Dr. George, Columbus, Director, Division of Endocrinology and Metabolism, The Ohio State University Hospitals.
Submitted August 31, 1979

enlarged. If it is, then the nodule is likely part of a generalized thyroid enlargement, a multinodular goiter. If the nodule is the only physical manifestation of thyroid abnormality, then it is by definition a single thyroid nodule. In the past, only patients with single thyroid nodules were considered suspect for thyroid cancer because neoplasia was thought usually to occur as an isolated event. For patients not exposed to x-ray therapy this is probably still largely true, but unfortunately, cancer as a late effect of x-ray therapy often is multifocal and may manifest as multiple palpable thyroid nodules.² Enlargement of cervical lymph nodes, particularly on the same side as the thyroid nodule, is a further indication of thyroid cancer with possible metastases. It is generally agreed that any patient with a history of external irradiation therapy to head or neck and physical finding of single or multiple nodules should undergo surgical exploration.¹

Experience With Patients Treated With External X-Ray Therapy to Head or Neck

Favus, et al³ evaluated 1,056 patients with a history of head and neck irradiation and found a prevalence of thyroid carcinoma of 9%. These patients were generally less than 40 years of age at the time of evaluation and the authors cited a previous study⁴ indicating that spontaneous occult thyroid carcinoma in this age group is rare. Therefore, the prevalence rate of 9% in this group is probably related to the radiation therapy. Roudebush, et al² further defined the natural history of 91 patients with radiation-associated thyroid cancer. All their patients had external irradiation therapy; none had radium rod treatment which exposes the thyroid to only a few rads. Also, we have not seen thyroid cancer following radium rod treatment of the nasal or oral pharynx. They compared their group of patients with radiation-associated thyroid cancer with a control group of 72 patients of similar age, who were treated for thyroid cancer during a similar period of time at their institution, and who were known not to have had previous head and neck irradiation. A remarkable finding in their series, which also has been reported by others, was the higher incidence of multifocal cancer in thyroid glands of irradiated patients as compared to the control group (46.5% versus 15.9%). This finding is consistent with the hypothesis that external x-ray therapy is a potent carcinogen for thyroid tissue giving rise to multiple thyroid cancers after a latent period of many years. To date most of the patients with radiation-associated thyroid cancer received their x-ray treatment as children. It is reasonable to believe that the thyroid of a child may be more susceptible than that of an adult to the carcinogenic effect of external x-ray therapy.

Management of Patients With History of External X-Ray Therapy to Head or Neck and Normal Thyroid on Physical Examination

An important unanswered question is whether the occurrence of thyroid cancer in patients who have re-

ceived external irradiation has reached a peak, or whether more thyroid cancers will occur in this group of patients in later years. If patients with a history of head and neck x-ray therapy are not found to have evidence of thyroid cancer when first examined, they should have regular checkups. If physical examination of the thyroid is normal I do not recommend a thyroid scan, although some physicians believe a scan should be obtained routinely in these patients. There is no question that the thyroid scan will disclose localized areas of decreased thyroid radioactive iodine uptake in some patients whose examinations showed normal thyroids. When operations are performed on patients with abnormal scans, some thyroid cancers will be found, although not necessarily in that part of the thyroid that showed the defect.

In the study of Favus, et al,³ the rate of carcinoma in patients with abnormal thyroid scan and normal physical examination was 27% compared with 37% for the group with palpable nodules. These two figures were not significantly different. A number of patients had thyroid cancers discovered at surgery in areas of the gland that did not correspond to any palpable or scan abnormality detected preoperatively. On the basis of these findings, it is likely that some patients with a history of head and neck irradiation, and with normal physical exam and normal thyroid scan nevertheless harbor a small thyroid cancer.

For this reason, I recommend to all patients with a history of head and neck irradiation, that they take 0.1 mg to 0.15 mg levothyroxine per day for an indefinite time until more facts are known about this problem. A serum thyroxine should be obtained several months after starting the medication to be sure that the dosage is not excessive, resulting in elevated serum thyroxine levels with subclinical hyperthyroidism. If the patient is unwilling to take a thyroxine tablet each day, then a scan is indicated. The scan should be performed with iodine 123 or technetium 99 m rather than iodine 131 because the former two isotopes deliver 2.8 and 0.1 rads, respectively, to the thyroid during a scan compared with 100 to 200 rads for iodine 131 scan.⁵ Thyroid suppression has been demonstrated to prevent thyroid cancer in irradiated rats but not definitely proven to be efficacious in people. However, it seems a reasonable and benign therapy in a group of patients that are a definite risk for cancer.

Therapeutic ¹³¹I

In contrast to external irradiation to the head and neck, ¹³¹I used therapeutically to treat hyperthyroidism has not been associated with subsequent development of thyroid cancer. ¹³¹I has been used therapeutically since the 1940s and in 1974 Dobyns, et al reported a cooperative follow-up study of 34,684 patients treated for hyperthyroidism.⁶ According to the study, 1,953 patients were treated 15 years or more, and 115 patients a minimum of 20 years. There was no known malignant lesion in either of these groups. In the total study population, there was no significantly increased incidence of thyroid cancer following therapeutic ¹³¹I. There are probably several

reasons for the safety of therapeutic ^{131}I in contrast to external irradiation. Many of the patients found to have thyroid cancer following x-ray therapy had the x-ray therapy during early childhood. Most physicians have limited ^{131}I therapy to adults and I am reluctant to treat a child with ^{131}I hyperthyroidism unless other therapy is contraindicated.

Patients treated with ^{131}I for hyperthyroidism commonly become hypothyroid implying near total destruction of the thyroid gland by ^{131}I . This is probably better than having persistent, living, but radiation-damaged thyroid tissue that may undergo neoplastic transformation after a prolonged interval. The current trend in ^{131}I therapy for hyperthyroidism is to give larger doses that will definitely cure the hyperthyroidism in a reasonable period of time. I consider it quite acceptable that most patients will become hypothyroid at some point after they are cured, as this is easily treated with replacement thyroxine. The incidence of hypothyroidism after surgical cure of hyperthyroidism also is quite significant.

Echography and Thyroid Nodules

In addition to physical examination and technetium scan (^{123}I), ultrasound or echography has become available in recent years to aid in evaluating the thyroid nodule. The thyroid echogram can easily distinguish the fluid in a cystic nodule from the solid tissue of an adenomatous or carcinomatous nodule. About 15% of thyroid nodules are cysts⁷ and thyroid cysts are rarely malignant. Thyroid cysts often are so tightly filled with fluid that they are impossible to distinguish from solid tissue on physical examination. The thyroid echogram is only helpful if the finding is a totally fluid-filled cyst. If the interpretation is solid tissue or solid tissue with areas of cystic degeneration, then the possibility of carcinoma remains. It is important to prove the diagnosis of thyroid cyst by needle aspiration and, by removing the fluid, cause disappearance of the thyroid mass. Clark, et al⁸ recently reported their experience with cystic neck masses diagnosed by echography in 40 patients. Thirty-six of these patients had thyroid cysts, two had thyroglossal cysts, and two had parathyroid cysts. All cyst fluid had benign cytology and in 14 patients operated on, the lesions were benign.

The advantage of cyst diagnosis by echography and needle aspiration is that surgery can be avoided. Levothyroxine, 0.1 mg to 0.15 mg per day for an indefinite time is probably worthwhile in these patients who have required diagnosis and treatment for a thyroid nodule. By suppressing Thyrotropin (TSH) secretion from the pituitary and thereby suppressing normal thyroid tissue, the hope is that the growth of other nodules will be prevented so that the question of thyroid cancer will not arise again. If a palpable nodule does appear while the patient is taking suppressive levothyroxine therapy, this clearly indicates abnormal thyroid tissue.

Treatment

The initial treatment of a patient with suspected thyroid cancer is an operation performed by a surgeon experienced in thyroid surgery. At the time of surgery the suspected lesion and a generous margin of normal tissue are removed and examined in frozen sections. If the frozen section indicates a benign lesion and all abnormal-appearing thyroid tissue has been removed, then no further surgery is performed until permanent histologic sections are available. If the frozen section at time of surgery, or a permanent section available a few days later, indicates malignancy, then an almost total thyroidectomy is performed preserving the posterior capsule of the thyroid so as to avoid damaging the recurrent laryngeal nerves and parathyroid glands. If lymph nodes are detected that appear as though they might contain tumor, they are removed. However, we never recommend radical neck dissection for papillary or follicular carcinoma of the thyroid because these carcinomas almost always are cured by thyroidectomy plus postoperative radioiodine therapy. About six weeks following near total thyroidectomy, a total body radioactive iodine scan is performed. By this time the patient should be hypothyroid with any functional tumor tissue under intense stimulation from thyroid-stimulating hormone from the pituitary. On the basis of this scan, the size and extent of tumor at surgery, and the age of the patient, we determined whether a therapeutic dose of 100 to 200 mCi ^{131}I is indicated. The patient is then treated with lifelong levothyroxine in a dose sufficient to completely suppress thyroid-stimulating hormone with periodic total body scans and therapeutic doses of ^{131}I as necessary.

Although there are theoretical risks of therapeutic ^{131}I , in practice it appears to be a benign therapy. The prognosis for the large majority of patients is excellent but a few patients have recurrences even after a disease-free interval of several years and some of these patients die of the disease.⁹ Therefore, continued observation and treatment, as necessary, is important.

References

1. U.S. Department of Health, Education and Welfare, Public Health Service, National Institutes of Health, *Information for Physicians: Irradiation-Related Thyroid Cancer*, Washington, D.C., Government Printing Office, DHEW: Publication No. (NIH) 77-1120, 1977.
2. Rouddebush CP, Asteris GT, DeGroot LJ: Natural history of radiation-associated thyroid cancer. *Arch Intern Med* 138:1631-1634, 1978.
3. Favus MJ, Schneider AB, Stachura ME, et al: Thyroid cancer occurring as a late consequence of head-and-neck irradiation. *N Engl J Med* 294:1019-1025, 1976.
4. Sampson RJ, Woolner LB, Bahn RC, et al: Occult thyroid carcinoma in Olmsted County, Minnesota: prevalence at autopsy compared with that in Hiroshima and Nagasaki, Japan. *Cancer* 34:2072-2076, 1974.
5. Silverman C, Hoffman DA: Thyroid tumor risk from radiation during childhood. *Prev Med* 4:100-105, 1975.
6. Dobyns BM, Sheline GE, Workman JB, et al: Malignant

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Clinical and scientific (continued)

and benign neoplasms of the thyroid in patients treated for hyperthyroidism: a report of the cooperative thyrotoxicosis therapy follow-up study. *J Clin Endocrinol Metab* 38:976-998, 1974.

7. Blum M, Goldman AB, Herskovic A, et al: Clinical applications of thyroid echography. *N Engl J Med* 287:1164-1168, 1972.
8. Clark OH, Okerlund MD, Cavalieri RR, et al: Diagnosis and treatment of thyroid, parathyroid, and thyroglossal duct cysts. *J Clin Endocrinol Metab* 48:983-988, 1979.
9. Mazzaferri EL, Young RL, Oertel JE, et al: Papillary thyroid carcinoma: the impact of therapy in 576 patients. *Medicine* 56:171-196, 1977.

☆☆☆

OUR NEW LOOK

Notice anything different about this month's *Journal*? Several editorial changes have been made which we'd like to draw to your attention . . . For example, a new, slightly larger type-face has been used to increase readability and enhance the general appearance of the publication; new department heads should make it possible to find your favorite department each month just by thumbing through the issue; a new "News" section has been developed for your information; and the new contents page should make everything easier to find. We hope you enjoy reading the new June issue . . . and we hope you enjoy our new look.

ACIP meet in Indiana

The American College of International Physicians (ACIP), founded in 1975 by a group of international physicians to maintain and advance the standards of medical education, practice and research, will hold its Annual Convention, July 16-20 at the Marriott Inn, Clarksville, Indiana (across the river from Louisville, Ky.).

A scientific program, worth 12 hours of Category I CME credit, will be included. For information, contact: Executive Director, ACIP, 3030 Lake Ave., Ft. Wayne, Indiana 46805, (219) 424-7414. Those interested in further details on ACIP may contact: C. Alex Alexander, M.D., or Sherman Kahn, M.D., (513) 268-6511.

April 12, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, April 12, 1980 at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Thomas W. Morgan, M.D., Gallipolis; Robert G. Thomas, M.D., Elyria; John J. Gaughan, M.D., Cleveland; David A. Barr, M.D., Lima; Stewart B. Dunsker, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; J. Hutchison Williams, M.D., Columbus; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; W. J. Lewis, M.D., Dayton; James E. Pohlman, Esq., Columbus; George N. Bates, M.D., Toledo; Richard L. Fulton, M.D., Columbus; Edward E. Grable, M.D., Canton; Jerry L. Hammon, M.D., West Milton; Charles L. Hudson, M.D., Cleveland; Robert N. Smith, M.D., Toledo; B. J. Anderson, Chicago, Illinois.

Those present from the OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; David W. Pennington; Eric Burkland; Jennifer O'Brien.

ADMINISTRATION DEPARTMENT

The minutes of the March 1-2, 1980 meeting of the Council were approved.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Auditing and Appropriations Committee — Dr. Williams presented the minutes of the April 11, 1980 meeting of the Auditing and Appropriations Committee.

The Council approved the recommendation of the Employees Pension Committee and the Committee on Auditing and Appropriations that: 1) the life insurance benefit of the

employees be changed from one based on salary to one based on a classification schedule; 2) that in order to reduce costs, the life insurance benefit be converted, where possible, to group term life insurance. Also, that the life insurance benefit be removed from the pension plan and made a free-standing program effective at the earliest date; and 3) that the pension committee be renamed the OSMA Employee Pension and Benefit Committee.

The Council voted to look into the cost of dictating equipment to receive messages during periods when the OSMA telephone system is unmanned.

The Council reaffirmed the investment policy of the Association as adopted in June, 1979.

The report of the Auditing and Appropriations Committee, as a whole, as amended, was approved.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Education — Dr. Spragg and Mrs. Dodson presented the April 3, 1980 minutes of the Committee on Education.

The Council accepted the recommendation of the Committee that the OSMA Voluntary Physicians Recognition Award Program be discontinued.

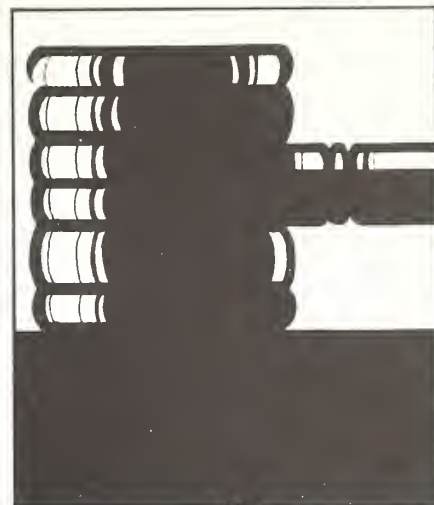
The minutes, as a whole, were accepted.

Annual Meeting Resolutions/Fiscal Notes — The staff was requested to prepare fiscal notes for each of the OSMA resolutions.

DEPARTMENT OF GOVERNMENT RELATIONS

Health Planning — Mr. Pennington reported on the proposed cuts in HSA appropriations in the Federal Budget and on HSA developments in Ohio.

Committee on Cost Effectiveness — Dr. Pfahl presented the minutes of the April 11, 1980 meeting of the Committee on Cost Effectiveness and they were approved.



council proceedings

DEPARTMENT OF ORGANIZATION SERVICES

Ohio Delegation to the AMA — The election of AMA delegation officers was affirmed by the Council as follows: Dr. Clarke, Chairman; Dr. Smith, Vice-Chairman; and Dr. Morgan, Cochairman.

A resolution to the American Medical Association was approved as follows:

Introduced by: Ohio Delegation
Subject: Candidate Interviews for AMA Councils

Whereas, There is a growing demand on Delegates' time and attention regarding the vital issues facing American medicine; and

Whereas, The Speakers have, in the past, asked for good judgment and restraint in utilization of time and money in promoting and evaluating candidates for AMA Councils; and

Whereas, The Speaker's letter dated March 27, 1980, encouraged State societies and associations to band together for the purpose of interviewing candidates prior to the opening session of the House of Delegates, thereby completing candidate interviews by noon on July 20, 1980; and

Whereas, Selection of the best qualified candidates for various Council positions is, and will continue to be, a very important function of the House of Delegates; therefore be it

RESOLVED, That the Speakers appoint an Ad Hoc Committee to study the method of candidate evaluation and selection for AMA Councils; and be it further

RESOLVED, That the Ad Hoc Committee make specific recommendations regarding this subject to the Board of Trustees so that a final recommendation can be considered by the House of Delegates at the Interim Meeting to be held in San Francisco, December, 1980.

JUA — Joint Underwriting Authority statistics were presented by Mr. Campbell, who also discussed hearings by the Ohio Department of Insurance on rules regarding the phasing out of the JUA and the rules having to do with discontinuing the Stabilization Reserve Fund.

PICO — The report on Physicians Insurance Company of Ohio was presented by Dr. Bates, Chairman of PICO's Board of Directors, who addressed the Council concerning the progress of the Company, which now has assets of about \$60 million.

Physicians Life Insurance Company of Ohio — A report on the Physicians Life Insurance Company of Ohio was given by Dr. Gaughan, chairman of its Board of Directors.

Professionals Insurance Company — Dr. Abromowitz, a member of the Board of Directors of Professionals Insurance Company, reported on the activities of that company.

Ad Hoc Committee to Review House of Delegates Policy — The staff was commended for the publication of OSMA House of Delegates Proceedings — 1929-1978 and the Report to the House of Delegates from the OSMA Council and the Ad Hoc Committee to Review OSMA House of Delegates Policy.

DEPARTMENT OF HEALTH EDUCATION

Committee on Cancer — The minutes of the March 5, 1980 meeting of the Committee on Cancer were presented by Mr. Clinger for information.

Committee on Mental Health — The minutes of the March 9, 1980 meeting of the Committee on Mental Health were presented by Mr. Clinger and *were approved.*

DEPARTMENT OF STATE & FEDERAL LEGISLATION

Task Force on Medical Licensure and Enforcement — Dr. Payne presented the minutes of the March 19, 1980 meeting of the OSMA Task Force on Medical Licensure and Enforcement.

The Council *approved* proposed language to modify the statutes of Ohio to the effect that licensees of the Medical Board "...shall provide to the Board satisfactory evidence that in the preceding two years the practitioner has completed 100 hours of continuing medical education in programs accredited by the Ohio State Medical Association, the Ohio Osteopathic Association, or the Ohio Podiatry Association. The applicant shall certify to the Board that he has completed such hours."

The Council *approved* the report of the OSMA Task Force on Medical Licensure and Enforcement and the following recommendations:

"(1) State Medical Board membership should remain at its current number, ten members.

"(2) The impaired physician program should be incorporated in a more complete way within the statute, in order to make more successful an already effective OSMA program.

"(3) Subpoena power should be granted to the Board, provided that the physician-patient privilege must operate to prevent public access to medical records. That is, documents subject to investigation by the Board must not be open to public scrutiny after an investigation.

"(4) Authority should be granted to the Board to take emergency disciplinary action against a practitioner without a hearing, if the Board determines that the practitioner's continued practice endangers the public. The hearing process must begin simultaneously with the temporary disciplinary action.

"(5) The Board should be authorized to hire its own trial attorneys to supplement counsel available from the Office of the Attorney General.

"(6) The current triennial registration program should be maintained, rather

than changed to an annual program. Fees should not exceed \$50 per year, provided that all new revenues be appropriated to give the Board an increased budget for expanded investigatory legal and support services.

"(7) In any appeal of a Board disciplinary action, the Court of Common Pleas should be directed to consider the public health and safety before suspending the disciplinary action.

"(8) The terms of all Board members should be reduced to four (4) years.

"(9) New malpractice reporting requirements are inappropriate. At most, only malpractice judgments against the physician should be reported."

Federal Legislation — Mr. Mulgrew discussed pending federal legislation.

The Council voted to request the Secretary of the Department of Health & Human Services to delay implementation of regulations concerning compensation for hospital-based physician's services under the Medicare and Medicaid Act.

State Legislation — Mr. Ayish discussed current state legislation.

The report of the Legislative Department *was approved.*

DEPARTMENT OF COMMUNICATIONS

Synergy — Ms. Mullinax reported on the promotion of *Synergy*, including an exhibit at the Ohio Hospital Association and negotiations with several firms who will distribute the publication to their employees.

It was voted to copyright *Synergy* as a publication.

Ohio State Medical Journal — Ms. Doll reported on the *Ohio State Medical Journal*.

FIELD SERVICE DEPARTMENT

Mr. Holcomb reported on the Department of Field Service.

Through Mr. Holcomb, the Miami County Medical Society requested and was granted the use of the OSMA Seal for its past president plaque.

The Ohio State Medical Journal

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

A letter from Dr. Camardese was referred to the Committee on Government Medical Care Programs.

COMMENDATION AND THANKS TO DR. GAUGHAN

The Council, with a rising vote of acclamation, expressed its thanks and appreciation to Dr. Gaughan for his services as Councilor and as Presidential leader of the Association. Dr. Gaughan thanked the Council for its many courtesies accorded to him by the Council during his term as President-Elect, President and Past President.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

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All classified ads will be printed anonymously by use of box numbers in a special classified ad section of **The Journal**. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of **The Journal** for additional listings.)



SURGEON: Cardiovascular thoracic with general and transplantation surgery secondary specialty. Available July 1980. Desires suburban metropolitan or metropolitan community of 50,000 or more people. Interested in solo, small group or institutional practice and/or academic appointment. Has passed specialty board examination in general surgery; eligible in cardio-thoracic July 1980. Contact Box P-50 c/o Ohio State Medical Journal

INTERNIST: Available December 1979. Interested in solo or small group practice in community that is rural with metropolitan ties or suburban metropolitan with population of 15,000 to 500,000 anywhere in Ohio but area 4. Eligible for specialty board December 1979. Contact Box P-51 c/o Ohio State Medical Journal.

UROLOGIST: Available July 1980. Interested in solo or group practice anywhere in Ohio. Eligible for specialty board examination May 1980. Contact Box P-53 c/o Ohio State Medical Journal.

OBSTETRICIAN/GYNECOLOGIST: Available July 1980. Eligible for specialty board examination June 1980. Interested in solo or small group practice in a community that is rural with metropolitan ties, suburban metropolitan, or metropolitan with a population of 50,000 to 500,000. Prefers areas 1, 2 or 5. Contact Box P-56 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1980. Eligible for specialty board examination June 1980. Desires community of 100,000 or more people that is suburban metropolitan or metropolitan. Interested in group practice, part-time academic appointment with part-time practice, or institutional practice. Contact Box P-45 c/o Ohio State Medical Journal.

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American Cancer Society

Obituaries

RICHARD C. BARR, M.D., Canton; Ohio State University College of Medicine, 1962; age 43; died March 21; member OSMA and AMA.

SHEPARD BURROUGHS, M.D., Ashtabula; Case Western Reserve University School of Medicine, 1937; age 69; died March 26; member OSMA and AMA.

MORRIS G. CARMODY, M.D., Painesville; Georgetown University School of Medicine, Washington, D.C., 1931; age 73; died March 31; member OSMA and AMA.

MILTON T. EBNER, M.D., Cleveland; St. Louis University School of Medicine, 1933; age 76; died March 27; member OSMA and AMA.

BENJAMIN FARAH, M.D., Cleveland; Universite de Paris, Seine, France, 1938; age 75; died March 27; member OSMA and AMA.

MARVIN GREEN, M.D., Toledo; New York University School of

Medicine, 1941; age 64; died April 7; member OSMA and AMA.

RALPH J. HONZIK, M.D., Culver, Indiana; St. Louis University School of Medicine, 1944; age 62; died March 20.

FREDERICK KAPP, M.D., Cincinnati; University of Pennsylvania School of Medicine, 1939; age 66; died March 31; member OSMA and AMA.

HARRY E. LANDT, M.D., Cincinnati; University of Cincinnati College of Medicine, 1928; age 77; died February 25; member OSMA and AMA.

FRANK N. NAGEL, M.D., Toledo; Ohio State University College of Medicine, 1924; age 85; died March 31; member OSMA and AMA.

ROBERT J. PEIRCE, M.D., Mansfield; University of Cincinnati College of Medicine, 1945; age 59; died April 1; member OSMA and AMA.

JAMES N. ALLEN, M.D., Columbus; Harvard Medical School, Boston, 1949; age 55; died April 1; member OSMA and AMA.

HUGH J. BAKER, M.D., Hamilton; University of Louisville School of Medicine, 1910; age 93; died March 31; member OSMA and AMA.

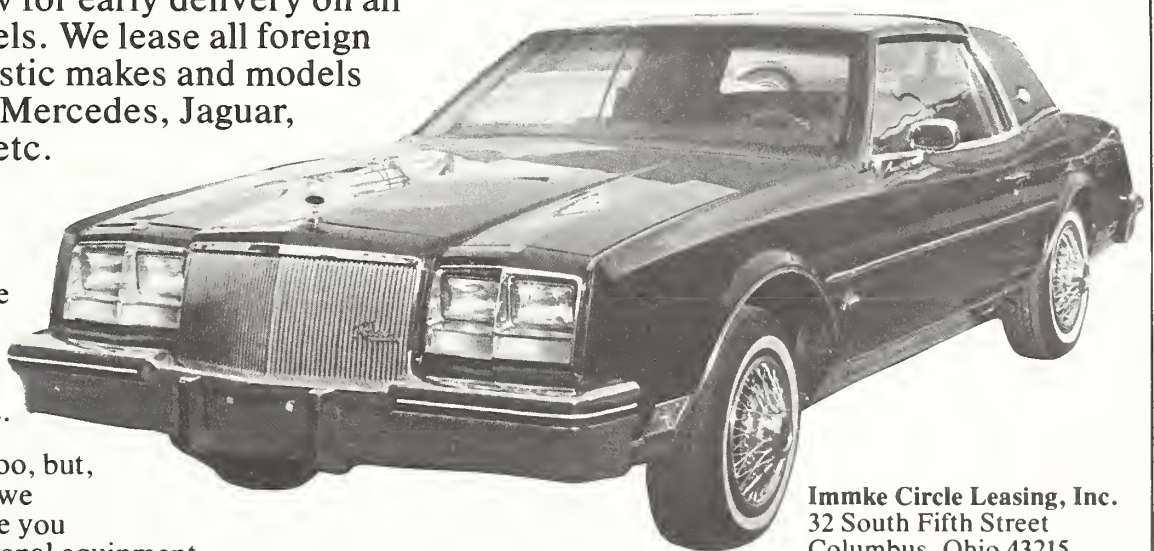
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Bernard Samtoy
Victor M. Sandoval
Rodolfo Z. Schneer
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STATE

MEDICAL BOARD BILL HAS FIRST HOUSE HEARING

The House Health and Retirement Committee conducted a first hearing on Senate Bill 368, the bill which expands the investigative and enforcement authority of the State Medical Board. Brief testimony was given by the OSMA, the Ohio Osteopathic Association, and the State Medical Board. Each organization supports the bill.

Rep. John Thompson, committee chairman, appointed a five member subcommittee to review the measure. The subcommittee will meet through the summer recess, in order to prepare the bill for full committee action when the legislature reconvenes in the early fall.

CPR TO BE TAUGHT IN PUBLIC SCHOOLS

House Bill 481 (Rep. Edith Mayer, R-Cincinnati) became law on June 20, 1980. Under the new law cardiopulmonary training (CPR) is a unit of all first-aid courses taught in Ohio high schools. These courses are prerequisite to graduation. School districts will either hire instructors trained in CPR from local health care agencies (such as the American Red Cross and the Heart Association) or contract with these agencies to train teachers in CPR as part of "teachers' in-service training." By purchasing both instruction and materials at reduced costs through the health care agencies, the school districts are expected to be able to implement this new law with minimal expense.

Parents may release their children from this graduation requirement, if they believe that their children are not emotionally or physically prepared for the CPR course.

NEWBORN TESTING BILL PASSED BY SENATE

The Senate passed HB 1056, which authorizes the Ohio Department of Health to test newborn children for certain genetic, endocrine, and metabolic disorders. The bill was drafted by the Department of Health. It is sponsored by Rep. Francine Panehal (D-Cleveland), and is supported by the OSMA.

Current law requires that all newborns be tested for phenylketonuria. The bill expands the testing to the detection of homocystinuria, galactosemia and hypothyroidism. In addition, the bill directs the Department to assist in the development of programs for education, detection, and treatment of genetic diseases.

The bill, which has already passed the House, now awaits signature by the Governor.

FEDERAL

HEALTH MANPOWER LEGISLATION MOVING

Health manpower bills are moving quickly in both Houses of Congress. The health manpower debate has centered on student assistance, institutional support, and the National Health Service Corps.

The current health manpower law, PL 88-129, expires this September. First enacted in 1963, the health manpower act has provided matching grants for the construction and expansion of health professions schools, as well as loans for students in schools of medicine, osteopathy, and dentistry. The original health manpower act has been amended five times during the past 17 years.

Various health manpower bills have been introduced this session. Two bills have become the apparent vehicles for extension. Those bills are HR 7203 and S 2375.

S 2375, the "Health Professions Education and Distribution Act of 1980," was reported out of the Subcommittee on Health and Scientific Research of the Senate Labor and Human Resources Committee. The House Committee on Interstate and Foreign Commerce passed HR 7203, the "Health Professions Educational Assistance and Nurse Training Amendments of 1980."

Several student assistance programs would be affected by both the Senate and House measures. Under S 2375, the **Health Education Assistance Loan (HEAL)** program would have its authorized funding set at 25% of the existing level. Amendments to the HEAL program would include: (1) loan limits would be raised to \$20,000 per year and \$80,000 cumulatively, with a floating interest rate, (2) students would become eligible for loans under the Higher Education Assistance Act of 1965, and (3) interest payments on HEAL guaranteed loans would be

continued on next page

deferred for an additional two years. Under HR 7203, the HEAL program would be retained with three major changes: (1) loan ceilings would be raised to \$20,000 annually and \$80,000 cumulatively, (2) the current 12% interest ceiling would be allowed to float, and (3) deferment of interest payments would be extended from three years to four years.

Under the Senate bill, the **Health Professional Student Loan (HPSL)** program would be eliminated. HR 7203 would cut authorized funding for HPSL by approximately 28%.

Both the Senate and the House measures would create new loan availabilities for medical students. S 2375 would establish a new **Service Contingent Loan** program for students with financial need. Maximum loans would be \$20,000 annually and \$80,000 cumulatively. To receive the loans, students must either volunteer to serve or be subject for conscription to serve in a "national priority position," which is defined as a health manpower shortage area. A 7% interest rate would be paid while the student is in school, in graduate training, in the Armed Forces, providing care for the government, serving in a health manpower shortage area, or practicing in a primary care specialty, preventive medicine or rehabilitative medicine. Otherwise, the interest rate would be allowed to float. During the first five years in an approved residency, the principal and interest would be deferred, while fulfillment of a period of service set by the Secretary would discharge all loan obligations.

Under the House bill, medical students would become eligible for the **Exceptional Financial Need (EFN)** scholarship program for the first two years of medical school. The bill would significantly increase funding for the expanded program.

Significant changes in federal institutional support would be made in both bills. Under the Senate measure, **Capitation Grants**, renamed **National Priority Incentive Grants**, would be available to schools meeting certain national objectives. Those objectives include: (1) clinical education directed toward serving underserved populations or in remote ambulatory settings; (2) education in nutrition, geriatrics, rehabilitation, or health economics; (3) placing 65% of first-year residencies in primary care; (4) community programs in preventive health; (5) programs

designed to increase the number of students accepting careers in clinical research; and (6) selection of at least 15% of the first-year class from "underrepresented minority groups."

HR 7203 would rename the Capitation Grant program as **Institutional Support Grants**. The intent of the bill is to entirely phase out the program, as funding is decreased to \$34 million for 1981, \$24 million for 1982, and \$12 million for 1983.

Under both bills **Construction Grants** would be limited to renovation of existing facilities. **Special project grants** in the Senate measure would be directed toward family practice, primary care residencies, preventive medicine, rehabilitative medicine, and curriculum development, while under HR 7203, emphasis is placed on "general internal medicine and general pediatrics," family medicine, and the establishment of departments of family medicine.

The **National Health Service Corps (NHSC)** program would be continued under both bills with some revisions. Under HR 7203, the Department of Health and Human Services (HHS) is directed to conduct an 18-month study into criteria for determining health care shortage areas, while health professions societies are given increased input into the determination of these criteria. Under S 2375, a new **State Service Scholarship** is created with matching grants made available to states to develop this program.

The consensus on Capitol Hill seems to be that there exists a need to continue some type of health manpower program. It is expected that health manpower legislation will pass before adjournment.

NATIONAL HEALTH INSURANCE STATUS

The following is an update on the status of National Health Insurance legislation pending before the 96th Congress:

Catastrophic Insurance Bills: Senate Finance Committee markup continues on S 350, S 351, S 760 (Long) and S 748 (Dole).

Pro-Competition Bills: Hearings held by Senate Finance Committee on S 1968 (Durenberger) and by W & M on HR 5740 (Ullman).

Universal Insurance Bills: There has been no Senate action on the Administration's or Kennedy's universal insurance bills (S 1812 or S 1720), which are pending in the Senate Finance Committee and the Senate Labor and Human Resources Committee. Joint hearings were held by IFC and W & M on the House versions of these bills (HR 5191 and HR 5400).

BILL STATUS

Child Health Assurance (CHAP): HR 4962 (Waxman). Passed House.

Child Health Assurance (CHAP): S 1204 (Ribicoff). Reported by Senate Finance Committee. **Clinical Laboratories Regulation (CLIA):** S 590 (Javits). Committee Report.

Clinical Laboratories Regulation (CLIA): HR 4894 (Waxman). Committee Report.

Drug Reform: S 1075 (Kennedy). Passed Senate.

Drug Reform: HR 4258 (Waxman). Passed Senate.

FTC Authorization: HR 2313 (Scheuer). Enacted as PL 96-252.

Health Manpower: HR 7203 (Waxman). Committee Report.

Health Manpower: S 2375 (Kennedy). Subcommittee report.

Hospital Cost Containment: (HR 2626) (Rangel). Passed House with Gephardt Substitute.

Hospital Cost Containment (S 570) (Nelson). Tabled in Senate Finance Committee; Senate Labor and Human Resources report ordered.

Medical Records Privacy: (HR 5935) (Preyer). House Government Operations Committee Report; House Interstate and Foreign Commerce Subcommittee markup; House Ways and Means Subcommittee hearings.

Medical Records Privacy: (S 865); (Ribicoff) Senate Governmental Affairs hearings.

Medicare/Medicaid Reform: (HR 934) (Talmadge). Committee report.

Medicare/Medicaid Reform: (HR 3990) (Rangel). House Interstate and Foreign Commerce Committee. Ways and Means Committee reports.

Medicare/Medicaid Reform: (HR 4000). House Interstate and Foreign Commerce Committee. Ways and Means Committee reports.

Mental Health Services Improvement: (HR 7299) (Waxman). Committee report.

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Karen S. Edwards

In this month's interview, an OSU medical student takes a look at medicine's turbulent present, and explores what the future may have in store, for both he and his chosen profession.



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House of Delegates reports, actions on resolutions, excerpts from the President's address and pictorial highlights of meeting activities are all included in this special section.



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The road to Boston 436

Karen S. Edwards

It's a long way from Canfield, Ohio to the Boston Marathon, but Jack Schreiber, M.D., tells us how he did it .. one step at a time.

Our Cover

"Strawberries", photographed by Vera Kalnins, Bucyrus, took "Best in Show" in this year's *Ohio State Medical Journal's* Photographic Exhibit contest. Mrs. Kalnins snapped the photo on a late afternoon in June, using a Nikon F2 Fotomic camera, a 135 mm Nikkor lens, and Kodachrome 64 film.



Clinical and Scientific

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...to the editor

COVER SHOTS

To the Editor:

I do not understand why you have a picture of the coast of California on the front cover of *The Ohio State Medical Journal*. California may be beautiful, but I am provincial enough to think that there are many worthy beautiful spots in Ohio that could be pictured on our front cover.

I resent it.

Sincerely,

/s/Richard J. Neubauer, M.D.
Cincinnati, Ohio

SYNERGY AND TEENAGE PREGNANCY

To The Editor:

Thanks for another timely edition of *Synergy* and for the article on "Teenage Pregnancy" (April, 1980). Our school administration and PTAs won't admit that children mature early and are sexually active, our physicians find the subject too controversial, so a number of children continue to bear children.

Back in the early 1920s I was an intern in the Women's and Children's Hospital in Detroit. Although I was a married woman, and a recent graduate of OSU's School of Medicine, I did not dream that a girl of 12 could get pregnant. My first morning on the ward for unwed mothers, a young, slight girl embraced me and told me she was glad to see a woman doctor. Two days later, on her 12th birthday, she was a mother. After all these years, that tragic moment in my life remains vivid.

May I suggest that you write a future article dealing with inherited diseases? The public is urged to fund many of these but they are rarely told that these diseases are hereditary and that genetic counseling is available.

Keep up the good work.

/s/Eva G. Cutright, M.D.
Wooster, Ohio

THIRD OPINION

To the Editor:

I can't think of a better way to introduce your new "second opinion" column than with the address by Dr. Sylvan Weinberg, in the May *Journal*. The points he made need to be pounded home time and time again.

Two questions: First, what is Dr. Weinberg's field of practice? Second, could you provide the citation for his quotation from the New England Journal of Medicine?

Thank you.

/s/Robert D. Gillette, M.D.
Toledo, Ohio

Editor's Note:

Dr. Weinberg specializes in cardiology and internal medicine in Dayton, Ohio. The citation for his quotation is "Medical Technology — A different view of the Contentious Debate over Costs," Thomas W. Maloney and David E. Rogers. *New England Journal of Medicine*, December 27, 1979, Vol. 301, Number 26, pp. 1413-1419.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Karen S. Edwards

MISCELLANEA

- Unsure as to how long you should keep your medical records — or even what you should put into them? The Physicians Insurance Company of Ohio (PICO) has a brand new 17-minute videotape that tells you all you need to know about the **elements of good medical record-keeping procedure**. Written and produced by V.F. Colon, M.D., and the Department of Family Medicine at the University of Cincinnati College of Medicine, the tape will be used to educate practicing physicians, residents and medical students. For more information, contact Linda Phelps Trafford, Director of Communications at PICO's home office.
- The Food and Drug Administration has said **Anturane**, a prescription drug used to treat gout, cannot be labeled and advertised for the prevention of death in the critical months following a heart attack. On analysis, the evidence favoring the drug for this purpose is not as convincing as it first appeared, Agency officials said, but they promised to "cooperate fully" in further study of the drug.
- **The United States Pharmacopeial Revision Committee**, which ensures the "accuracy and adequacy" of the nation's legally recognized standards for drug quality, purity and strength have added, for the first time, representatives from the fields of nursing, veterinary medicine and consumer interest to their committee. The new members join representatives from medicine, pharmacy and the allied sciences for five-year terms.
- **Attention medical writers!** *Home Health Review*, a quarterly scholastic journal published by the national Association of Home Health Agencies, is seeking articles from a broad range of experts in the field of home health care. Suggested topics include: Innovative Home Care Programs, the Physician's Role in Home Care and The Hospice Concept at Work in Home Care. Submit manuscripts and/or inquiries to: *Home Health Review*, National Association of Home Health Agencies, 426 "C" Street, N.E., Suite 200, Washington, D.C. 20002.

On the labor front . . .

Pregnant women living or working in a stressful environment may be jeopardizing the health and reproductive capabilities of their children, claims Dr. Lorraine Roth Herrenkohl, a professor of psychology at Temple University, Philadelphia, Pennsylvania.

Dr. Herrenkohl tested the effect of stress on pregnant laboratory rats (whose ovaries operate in the same

manner as humans) and concluded that stress hormones, coursing through the body of the mother-to-be may form a "hidden birth defect," causing female children to face reproductive difficulties later in life.

"By stressful human circumstances, we're talking about loss of a loved one by death or separation, marital discord, fighting or job pressure," Dr. Herrenkohl clarified.

Domestic Help need coverage, too

Householders who employ domestic help may want to read the new pamphlet, "Workers' Compensation for Domestic Workers," published by the Ohio Bureau of Workers' Compensation. The brochure explains legal responsibilities (any domestic worker who earns \$160 or more per

calendar quarter must be covered by workers' compensation under Ohio law) as well as how to provide such coverage. The brochure is available by writing to: Domestic Coverage, Inquire and Response Section, Bureau of Workers' Compensation, 246 N. High Street, Columbus, Ohio 43215.

A new look at the heart

An eight-member radiology team from the Cleveland Clinic has developed a new, quicker means of viewing the heart and arteries of the body than conventional angiography. Called digital subtraction angiography (DSA), the new system uses a digital computer, a fluoroscope and radiologic equipment to suppress radiologic pictures of bony and soft tissues and provide a clear, "motion picture" view of the vascular region. Data is stored in a memory bank and can be retrieved at will.

Although the DSA is about one year away from practical hospital use, it does promise other advantages over current angiography. It can, for example, be performed on an outpatient basis in about 15 minutes, instead of requiring up to a day of hospitalization and contrast dye can be injected intravenously through the arm, instead of through a catheter.

"The advantages of such a procedure are obvious," said Thomas F. Meany, M.D., chairman of the Clinic's Division of Radiology, and one of the team investigators. "It is simple and faster than conventional angiography and therefore can be performed at much less expense to the patient."

zzzzzzzzzz

Suffering snorers!

Bed partners of people who snore heavily are apparently not the only ones suffering.

Many physicians are not aware of problems associated with heavy snoring, says David W. Hudgel, M.D., of the University of Colorado Health Sciences Center, in a recent issue of Health Insurance News. Dr. Hudgel comments, "Heavy snoring prevents restful sleep which, in turn, causes irritability, depression and unclear thinking."

As if that weren't enough, he adds that snoring can also put a strain on the cardiovascular system. Apparently those loud snorts a sleeper makes when he needs air, can lead to irregular heartbeats and respiratory problems.

Meetings

"How to Use the New Self-Help Alcoholic Treatment Method;" August 24-29; Britannia Beach Hotel, Paradise Island, The Bahamas; Sponsor: Rational Behavior Therapy Center at the University of Kentucky College of Medicine. Contact: Barbara Hood, Rational Therapy Center, 678 Allwyn Street, Baldwin, New York 11510.

"Intraocular Lens Implantation Surgical Symposium;" September 26, 27; Vernon Manor Hotel, 400 Oak Street, Cincinnati; Sponsor: Bethesda Hospital and Deaconess Association along with the University of Cincinnati Office of CONMED; 10 credit hours Category I; fee, \$150. Contact: Thomas O'Connor, Director of Information Resource Center, Bethesda Hospital, 619 Oak Street, Cincinnati, Ohio 45206.

Fifth Annual International Body Imaging Conference; October 11-19; Kauai Surf Hotel, Kauai, Hawaii; Sponsor: Department of Radiology, West Park Hospital; 30 credits Category I; fee, \$335, interns, residents and technologists with letter, \$225. Contact: Conference Coordinator, West Park Hospital, Department of Radiology, 22141 Roscoe Blvd., Canoga Park, California 91304.

International Food Allergy Symposium III; October 17-21; Boston, Mass. Contact: Shirley Schoenburger, Executive Secretary, American College of Allergists, 2141 Fourteenth Street, Boulder, Co. 80302.

66th Annual Clinical Congress of the American College of Surgeons; October 19-24; Atlanta Hilton and the Hyatt Regency Atlanta, Atlanta, Georgia. 18 postgraduate courses, panel discussions, symposiums, etc.; fee free for Fellows of the College whose dues are paid for 1979; non-Fellows, \$190; federal service physicians, \$175; surgical residents with letter verifying residency, \$95.

46th Annual Scientific Assembly of the American College of Chest Physicians; October 26-30; Sheraton Boston Hotel and the Hynes Auditorium Convention Center, Boston, Mass.; over 30 hours of Category I CME credit.

Familial cancer studied

The genetics of cancer susceptibility in humans will be the major area of study in the Institute for Familial Cancer Management and Control, recently established in Omaha, Nebraska.

One of the Institute's major goals is to inform physicians that means exist for predicting cancer risks in kindreds.

"When such risk factor information is known," said Henry T. Lynch, M.D., a founder of the Institute, "the treating physician is better able to alert patients to symptoms. Such information has also been shown to facilitate screening and early diagnosis by the primary physician."

Success story

Over the past two years, physician response to the AMA's call for voluntary fee restraint has resulted in fee increases that are well behind the rate of inflation in the general economy. The story, told by *AMA Highlights*, says that in 1978, the all-items category of the Consumer Price Index rose 9.0 percent and physicians' fees rose 8.1 percent. In 1979, the CPI increased 13.3 percent while physicians' fees rose 9.4 percent. To add to the good news, the AMA also was able to point to its continuing participation in the Voluntary Effort to Contain Health Care Costs.

Drawing interest

Now is the time for all physician-artists to select some of their best creations to send to the American Physician's Art Association's (APAA) annual exhibit and contest, scheduled this year for November 16-19 in San Antonio, Texas. First, second and third prizes are awarded in: Oil and acrylics (classical and modern), water color, sculpture, arts and crafts, photography and graphics. Special masters awards, honorable mention and best of show awards also will be presented. There is consideration for advanced and beginning artists. Physicians must be members of the APAA to enter. Membership details may be obtained by writing: Milton S. Good, M.D., Treasurer, APAA, 610 Highlawn Avenue, Elizabethtown, Pennsylvania 17022.

more news next page

BOOK SHELF

Sports Medicine for the Athletic Female.

Edited by Christine E. Haycock, M.D., Medical Economics Books, \$27.50, hard-cover only.

Described as the definitive manual for the "care and feeding" of women athletes, Dr. Haycock, a woman athlete as well as a surgeon, has assembled information from 30 authorities in physical education and medical specialties and directed the information specifically to the female athlete.

Enhanced throughout by photographs, line drawings and charts, the 325-page book explores such topics as the psychology of the female athlete, cardiovascular considerations and proper clothing and equipment.

Female athletes as well as anyone with direct athlete/patient contact will find this book of interest for its medical advice, its help in improving athletic performance and in preventing sports injuries.

The book is available for \$27.50 per copy (plus \$1 handling charge) from Medical Economics Books (2120-DPRDO), Box 157, Florence, Kentucky, 41042. Payment should accompany orders.

Questions Parents Ask About Nephrosis.

Ronald J. Kallen, M.D., National Kidney Foundation.

This general information booklet, written by a Cleveland Clinic pediatrician, answers questions most frequently asked by parents whose children are afflicted with nephrosis — a chronic kidney disorder.

Nephrosis often begins in early childhood and each year afflicts two out of every 100,000 children aged 16 years and under, in the country. The disease usually results in insidious body swelling which, the author claims, is devastating to a young child's self-image.

After treating numerous cases of nephrosis, the author found that parents of children afflicted with the disorder were asking many of the same questions — thus his reason for writing the booklet.

Copies may be obtained from: The Kidney Foundation of Ohio, 2022 Lee Road, Cleveland, Ohio 44118.

Choices: Realistic Alternatives in Cancer Treatment.

Marion Morra & Eve Potts, Avon Books, \$8.95, soft-cover only.

Choices is a book that has been specifically written for the cancer patient — to guide him or her through the "bewildering maze" of doctors, hospitals and diagnostic tests, as well as the side effects and after effects of various treatments. Called by the publishers "the most comprehensive source book for cancer patients and their families ever published," Choices includes within its 784 pages, detailed information on each type of cancer as well as such topics as coping with pain, living with cancer and a complete nationwide listing of treatment centers. Said American Cancer Society President, S. B. Gusberg, M.D., of the book: "It raises most of the questions the public is asking and answers them simply and clearly in lay language."

The book is available for \$8.95 per copy (plus 75¢ for handling) from Avon Books, Room 312, 959 8th Avenue, New York, New York 10019.

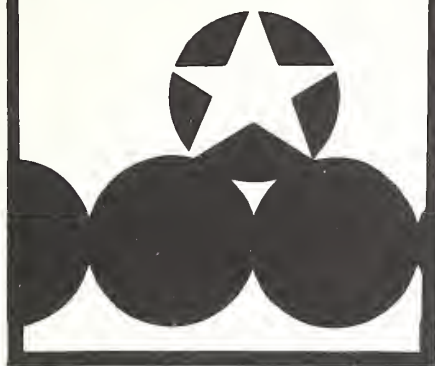
Help them fight back!

The Ohio State Medical Association has developed a set of four posters designed to help inform your patients about their role in controlling rising health costs. The posters discuss the costs associated with smoking, alcohol, and drug abuse and a sedentary lifestyle and what your patients can do to not only help control costs, but be healthier at the same time.

Let your patients know you're concerned about rising costs and you need their help in controlling them. These colorful, informative posters are available at \$4.95 per set; 2 sets for \$8.00, and 3 sets for \$10.00.

Send your check or money order made payable to the OSMA to: OSMA, Attention: Department of Communications, 600 S. High St., Columbus, Ohio 43215.

COLLEAGUES IN THE NEWS



JOHN E. ALBERS, M.D., will represent the First District on the Council of the Ohio State Medical Association, replacing Stewart B. Dunsker, M.D., who recently was named the Association's new president-elect.

Dr. Albers practices cardiovascular and thoracic surgery in Cincinnati. A graduate of the University of Cincinnati's College of Medicine, Dr. Albers has been an active member at the local, state, and national level of organized medicine. In addition to past service as an alternate delegate to the AMA and as a delegate to the OSMA, he is a board member of the Ohio Medical Political Action Committee and has served on numerous committees of the AMA, OSMA, and the Academy of Medicine of Cincinnati.

ROBERT A. BACANI, M.D., Youngstown, was elected president of the Eastern Ohio Chapter of the American Heart Association.

ALBERT A. BRUST, M.D., Kettering, was elected president of the American Heart Association, Ohio Affiliate, Inc., and **ROBERT H. McMASTER, M.D.**, Cincinnati, president-elect.

OSCAR BUDDE, M.D., was named medical director for the Salem Board of Health.

JAMES CERILLI, M.D., Columbus, was elected president of the American Society of Transplant Surgeons.

HENRY G. CRAMBLETT, M.D., Columbus, acting vice-president for medical affairs and dean of the Ohio State University College of Medicine, was elected president of the Federation of State Medical Boards. Dr. Cramblett said one of his main projects as president will be to make licensing laws more uniform from state to state.

Dr. Cramblett also was appointed chairman of the Committee on Certification, Subcertification, and Recertification of the American Board of Medical Specialties.

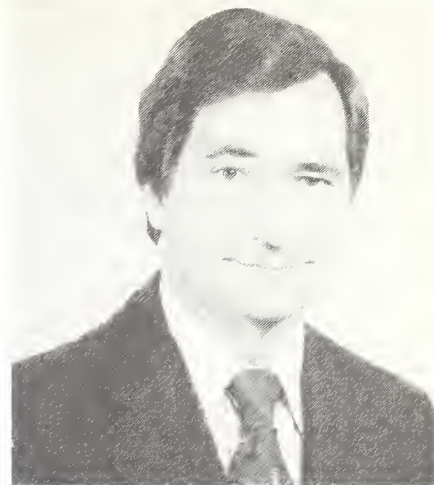
DONALD K. EBERSOLD, M.D., has closed his office in Millford where he has practiced for over 25 years. Dr. Ebersold will be training future family doctors as he becomes assistant professor of family medicine at the University of Cincinnati.

ROBERT K. FINLEY, JR., M.D., Dayton, was recently elected president of the Ohio Chapter of the American College of Surgeons. Other officers include: **LARRY C. CAREY, M.D.**, Columbus, president; **WILLIAM V. SHARP, M.D.**, Akron, treasurer; and **ROBERT M. ZOLLINGER, JR., M.D.**, Cleveland, secretary.

AVRUM I. FROMISON, M.D., Cleveland, was appointed director of the department of orthopedic surgery at Mt. Sinai Hospital. Dr. Fromison is known for his work in orthopedic surgery and sports medicine and holds the patent on the original tennis elbow support.

Officers elected to the Ohio State Radiological Society include: **WILLARD J. HOWLAND, M.D.**, Canton, president; **D. KIEFER CAMPBELL, M.D.**, Dayton, president-elect; **CHARLES M. KLEIN, M.D.**, Toledo, secretary; and **KONRAD KIRCHER, M.D.**, Dayton, treasurer.

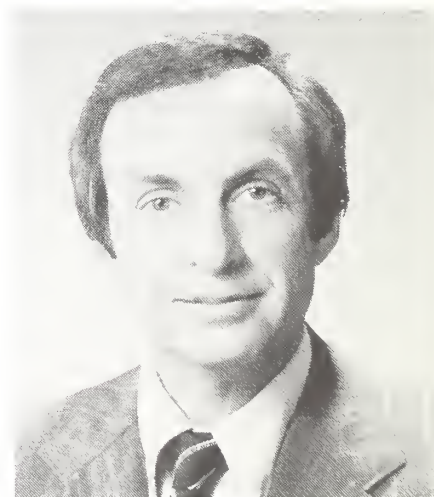
Newly elected officers of the Wyandot Memorial Hospital medical staff are: **PRASAD KAKARALA, M.D.**, Sycamore, chief-of-staff; **HERSHEL RHODES, M.D.**, Upper Sandusky, vice chief-of-staff; and **DONALD SMITH, M.D.**, Sycamore, secretary-treasurer.



John E. Albers, M.D. . . . OSMA's new Councilor from the First District.



Frederick P. Zuspan . . . new test committee member.



Avrum I. Fromison, M.D. . . . Mt. Sinai's new director of orthopedic surgery.

The American College of Obstetricians and Gynecologists (ACOG) National District Service Award was presented to **ARTHUR G. KING, M.D.**, Cincinnati.

A Founding Fellow of ACOG, Dr. King has been District V Secretary, 1954-1957, Chairman, 1956-1960, Vice-President, 1963-1964, Chairman of Committee on Infant Adoptions, and the Committee on Administration.

Dr. King is active in numerous medical societies. He has written many articles and lists more than 65 publications.

A "roast" was held in April at DeLuca's Place in the Park, in honor of **HENRY C. MARSICO, M.D.**, the Lorain Lions Club's "Man of the Year, 1980."

Dr. Marsico, a skin specialist and anesthetist, has practiced in Lorain since the end of World War II, and has been Lorain City Health Commissioner since February 1975.

LEONARD N. OZEROFF, M.D., Warren, will serve as medical director for the Health Maintenance Organization being developed by Blue Cross in Eastern Ohio.

RICHARD J. NOWAK, M.D., was elected president of the Cleveland Academy of Medicine. Other officers include: **ROBERT M. ZOLLINGER, JR., M.D.**, Chagrin Falls, president-elect; **MATTHEW BISCOTTI, M.D.**, Parma Heights, vice-president; and **FRANKLYN SIMECEK, M.D.**, Brecksville, secretary-treasurer.

ALEXANDER K. PHILLIPS, M.D., Youngstown, was honored for his "many years of dedicated service to church, community, and humanity" at a testimonial banquet on May 1, at St. John Greek Orthodox Fellowship Hall. Dr. Phillips presently is senior surgeon at St. Elizabeth Hospital, Cincinnati.

LEROY RODGERS, M.D., Toledo, was named chief of the Medical College Hospital medical staff.

C. B. SCHOOLFIELD, M.D., Upper Sandusky, was honored at the inaugural Citizens Award Dinner.

The Ohio State Neurosurgical Society honored **JULIUS WOLKIN, M.D.**, Cleveland, as "Neurosurgeon of the Year."

SAMUEL WEIR, M.D., Minerva, was named Man of the Year at the Inter-Club Banquet hosted by the Minerva Lions Club and including Rotarians, Kiwanis, and Lions members and guests.

FREDERICK P. ZUSPAN, M.D., Columbus, was appointed to a test committee of the National Board of Medical Examiners. Dr. Zuspan will serve on the Part III Patient Management Problem Test Committee. The committee is responsible for determining the direction and content of examination subject matter and assuring the quality and integrity of the overall evaluation system of the National Board of Medical Examiners.

Dr. Zuspan is professor and chairman of the department of obstetrics and gynecology at Ohio State University, director of the American Board of Obstetrics and Gynecology, and is active in many professional and community organizations.

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FUTURES

On
Record

By Karen S. Edwards

Editor's Note: Christopher Desch is a medical student with one more year to complete at Ohio State University's College of Medicine, before pursuing a career in internal medicine. During May and part of June, Mr. Desch served a rotation in community medicine at the Ohio State Medical Association, and attended the OSMA Annual Meeting in Cincinnati. The Journal asked Mr. Desch his opinions of the Annual Meeting, organized medicine, and physicians' image from his student's point of view.

"To me, the AMA has a very conservative image and a conservative outlook on medical legislation. My perspective since being with the OSMA, however, has changed, and I see the potential of the organization."

OSMA Journal: Before coming to serve your rotation at the Ohio State Medical Association, what were your thoughts on organized medicine?

Desch: I was concerned about it, but I was not well versed in what it all meant. I was in the American Medical Student Association, and we've talked about some of the issues facing medicine today, but I never got into the complexities of them.

Journal: You have been with the OSMA a month now. Have your views changed regarding organized medicine, and if so, how?

Desch: Initially I was skeptical about organized medicine. To me, the AMA has a very conservative image and a conservative outlook on medical legislation. My perspective since being with the OSMA, however, has changed, and I see the potential of the organization. Its active members and leaders are genuinely interested in the practice of medicine and in legislation, but there are shortcomings in the organization itself.

Journal: What do you see are the shortcomings?

Desch: There needs to be an innovative outlook on the issues threatening organized medicine. A lot of the issues, for instance, the nurse-practitioner

legislation and some of the ethical matters facing the OSMA and the AMA, could be changed by the organization. But the organization itself needs to change and keep up with the times.

Journal: In what way?

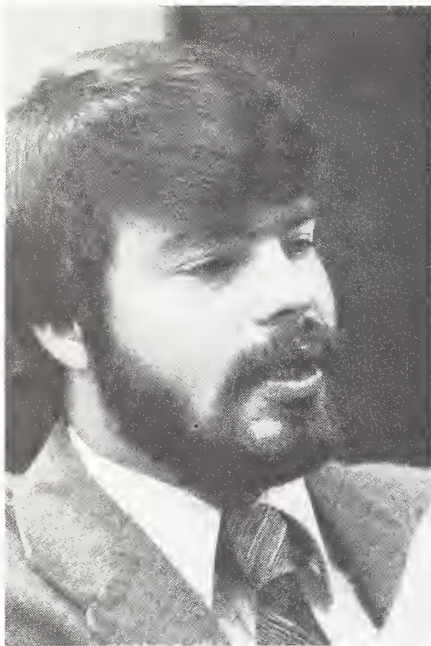
Desch: Most of the men and women in organized medicine have a one-sided opinion about issues and they argue their position ineffectively. Their public image is hurt by that — by the way they present their own opinions. But it's important to say that the opinions they have, for the most part, are concerned with patient care and the future of medicine.

Journal: How would you improve the image they're projecting?

Desch: Instead of immediately saying no when an issue involves encroachment, or in the way health care is being delivered, they should negotiate, listen, compromise. They need to aggressively and quickly seek out alternatives that, with good public relations, could make the AMA's image come off better, and could be a lot more helpful in these changing times.

Journal: So you still feel that organized medicine has a conservative image?

Desch: I think that the general public has the impression that the AMA and



Christopher Desch

Desch: I think organized medicine needs new people and new ideas, but I don't think that necessarily has to come from students. I think it's wrong to say that only young people can do good things. I was so impressed at the OSMA Annual Meeting by how much time the physicians involved in organized medicine spend studying the issues. They were so far from the image I originally had of them being stodgy, unchangeable, nonphilosophical people. They really are caring, interested physicians who are preserving the rights they have in their practice, and are concerned about preserving them for the future. But while I think that's good and very honorable, I still feel that the practice of medicine will have to change.

Journal: In what way?

Desch: I think the delivery of health care is going to change legislatively. So many moves by other people — the federal government and other practitioners — are forcing medicine to take another outlook. All the changes that may be inevitable are not bad, but it's important for organized medicine not only to stay on top of them but

while still keeping the physician as a leader.

Journal: You feel, then, that the peripheral personnel who participate in health care delivery can prove valuable in a physician's practice?

Desch: Yes. I know physical therapists and nurse practitioners and extremely competent allied health professionals who are smart, enthusiastic, and idealistic themselves. All the things they purport they can do — they do very well, and very responsibly. So that makes me wonder why they can't be included in a practice. I can see myself using these people in my own practice some day.

Journal: Do you think that, when you are in practice, you will get involved in organized medicine?

Desch: Organized medicine is actually only one facet of medicine, and I know that for the majority of physicians it holds no place in their practice. Most physicians don't know or care what the OSMA or AMA think. They don't know the potential of the organization. They're only concerned with their

organized medicine are only in existence to protect their own interests. Most people don't even know about the services which organized medicine provides the physician — the insurance, the legal and legislative help, the help it provides physicians who are having trouble in their practice. In many aspects, organized medicine is helping protect the patient, too, but most people just don't see that.

Journal: Do you think organized medicine will change its image, or do you see it following its conservative outlook for a time yet?

Desch: I don't know. Naturally, I'm looking at the subject idealistically and naively now. I can't speak from my own practice. But I think it's going to take some idealism and innovative thought and leadership by physicians in order to change and improve the conservative image they have.

Journal: Do you think that the students coming out of medical school are going to get involved in organized medicine and provide this?

"If the changes (in medicine) are inevitable, organized medicine will have to switch from a defensive to an offensive position to make these changes beneficial."

keep ahead of them as well. If the changes are inevitable, organized medicine will have to switch from a defensive to an offensive position to make these changes beneficial.

Journal: What offensive moves do you think organized medicine should make?

Desch: Instead of defining or describing the practice of someone else's field, for example, we should listen to what those practitioners have to say and try to work out a way of improving the delivery of care — keeping a physician as supervisor, but compromising their aims and our goals. Organized medicine should initiate that sort of positive action instead of introducing defensive amendments. We should try to consider how other practitioners' ideas could be incorporated into health care,

practice and their patients. As far as I'm concerned, I see that there's a place where I could get involved, there are openings, but I don't know how involved I would get.

Journal: What would be an incentive, as far as you are concerned, to encourage physician participation?

Desch: I wish I had an answer to that. I think if I did I could really sell the organization. I guess, for me, it might be a change of image. But it's hard to explain what a real incentive might be. There's no way for any physician in Ohio to know what the medical association does, unless they spend time there. They don't know all the hours that the staff goes through, the time and travel spent arguing legislation, working out insurance claims. Those are the things that affect only one or two people at a time.

Journal: Do you think if physicians realized all that organized medicine was doing for them, there would be more participation?

Desch: I think there might be, but there will always be physicians who refuse, and maybe rightfully so, to look into that sort of thing. They are so busy. I was lucky because I could spend a whole month in organized medicine without having to read journals, or look at patients, but it took a long time, even then, to get a perspective, and these people probably never will. Maybe it will take a crisis in health-care delivery to get people really involved.

Journal: Do you think that health-care is close to approaching a crisis?

Desch: I think there could easily be a crisis in the future that would change health-care delivery radically — especially in matters relating to health insurance, but in other things, too.

Journal: Do you see these changes as necessarily bad, or just different?

Desch: Some of the legislation that may come up could be very detrimental to patients and physicians, and would only be done for economic reasons. If it came down to that, then I think more physicians would be less complacent.

Journal: Do you think physicians are too complacent?

Desch: About their own association, yes.

Journal: What were your impressions of the OSMA's Annual Meeting?

Desch: It was very well organized. The physicians involved were very conscientious and spent a lot of time thinking about the issues and about the future. I enjoyed the discussions I had with some of the physicians there. They seemed willing, even excited to talk to me. They really listened to my opinions and seemed genuinely concerned about them, and I think that's very positive. They know they need different opinions. I even told them about my initial image of organized medicine. They weren't surprised to hear my views, and they asked a lot of questions about how I thought they could change that image.

July 1980

I wish I had more answers for them. They're really concerned. I think that the people that are in the organization now are working hard.

Journal: Do you think medicine will be different by the time you go into practice?

Desch: I don't think there's going to be any change in how doctors and patients get along, or in how patients respect doctors. The basic grass-roots role of medicine won't change.

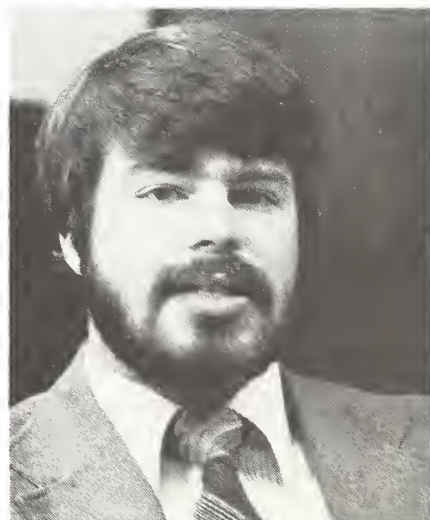
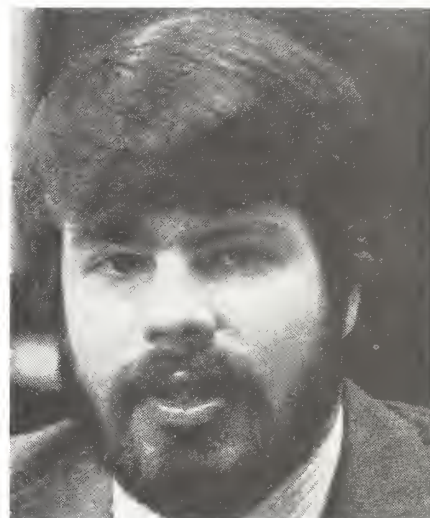
Journal: What lasting impressions do you have of organized medicine and how will the time you've spent here influence you in your practice?

Desch: After May is over, I plan to follow the AMA and OSMA more closely on their opinions on issues, to become involved when it's possible for me, but it will be a long time before it's possible or encouraged. You just have to experience all the good that organized medicine does for everyone. It would be time consuming to explain to everyone all the positive features and benefits they could be reaping from joining the organization. How interesting some of the questions that are facing us really are if you had time to get involved with them and discuss them! It's important to be a member of organized medicine not only for the services it provides the individual physician, but for what it does for the overall practice of medicine.

Journal: Do you think organized medicine will grow stronger, with more physician participation?

Desch: I hope so, but I don't think doctors always know what's best for them. For example, I don't think they appreciate all the complexities of an issue the same way the Association does. If they disagree with a stand taken by organized medicine, they'll refuse to join without knowing how the organization really arrived at that stand. I think, too, that generally physicians don't know what's involved with getting involved. They don't really know how much time it takes. One way to get more people involved might be to expose them early as students, but in our present system that's almost impossible. And that's a shame. It's certainly been a valuable learning experience for me. **OSMA**

Karen Edwards is Executive Editor of the *Ohio State Medical Journal*.



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THE judicious allocation of resources for medical care is becoming of increasing concern to the physician. The physician occupies a unique position both as a quasi-fiduciary of the patient's finances with regard to health services and as the prescriber of those orders which result in the expenditure of the funds. While the physician has no control over hospital charges per se, he does have direct control over the length of hospital stay and physicians' orders.

There is an implied responsibility for the physician to utilize resources in the most efficient manner possible. A system of "medico-economic triage" must be developed in order to aid the physician in selecting the most cost-effective means of achieving this goal. Most practicing physicians have not received any formal or even informal instruction on this subject. Some beginning efforts are now underway in certain colleges of medicine,* but there is an urgent need to expand the efforts to all schools of medicine, to residency training programs, and to physicians in private practice.

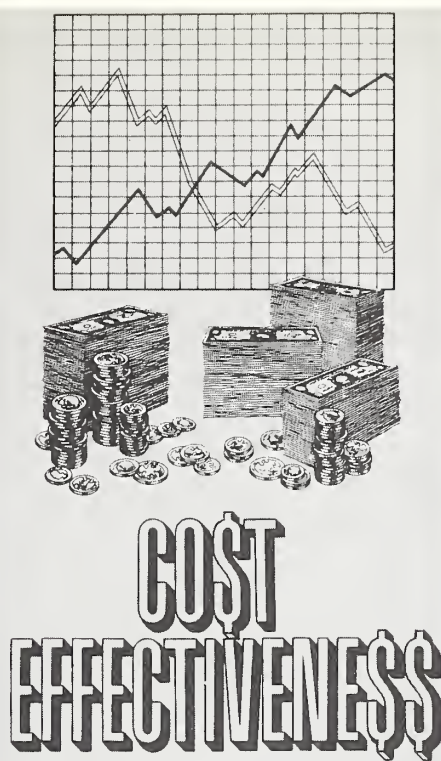
The Clinico-Economic Conference was developed as one means of achieving more cost-awareness among physicians. The overall goal of the CEC program is to constrain escalating costs of health care while at the same time increasing the efficiency of the delivery of health care. The two goals are not mutually exclusive.

The CEC concept was begun in 1979 at Good Samaritan Medical Center, a 420-bed community hospital, as a pilot program. An example of the CEC "Concerned with Routine Orders for Acute Myocardial Infarction Patients" is described:

For demonstration, routine admitting orders (using projected transparencies) were presented along with charges for the individual tests illustrated beside the orders. A comparison of various costs, clinical methods, and clinical benefits was discussed. In addition, copies of the Master Fee Schedule for the hospital were made available to the physicians.

The moderator led the discussion with considerable audience participation. It appeared that:

1) Most physicians were not aware of the specific costs of hospital room and



The clinico-economics conference: a medico-economic triage

by Benjamin W. Gilliotte, M.D.

board, laboratory and x-ray services, and medications;

2) The SGOT, SLDH, and SHBD were somewhat redundant if one ordered the SCPK-MB, which was done in all cases. The SCPK-MB was thought to be more specific and sensitive. However, certain of these cardiac enzymes might be indicated in particular cases, but should be ordered selectively rather than routinely;

3) Routine or standing orders are not advisable since there are no "routine acute myocardial infarctions." Too, there is a built-in pitfall in routine orders in that previously indicated tests or medications may have become obsolete but the orders are not deleted because the physician does not "think about them." With the total costs for daily X 4 cardiac enzyme panels being \$99 per patient there could be a potential saving of over \$15,000 annually, based on the average number

of MI admissions at this hospital, if these tests were not ordered routinely. If this one CEC were presented at all hospitals in the U.S. and there was only a 50% reduction in the ordering of these tests, there would be a considerable saving.

Subjects under consideration for future Clinico-Economic Conferences include:

- Pitfalls in Routine or Standing Orders on All Hospital Patients
- Should Antibiotic Orders be Open-Ended?
- IPPB-Is There A Better Alternative?
- Rational Ordering of Arterial Blood Gases.
- Is the Routine Chest X-ray Examination Cost Efficient and Clinically Indicated?
- Open Reduction of Hip Fractures-A Cost Comparison.
- Is the Skull X-ray Series Over-Ordered?
- Is a Full Coagulation Profile Really Indicated for All Patients Undergoing (T and As)?

The structure and planning of the CEC begins with a need assessment and topic selection. The assessment may be ascertained from medical audits as well as input from the medical staff. A moderator and, in some instances a panel, are selected and program objectives are developed. Visual aids such as transparencies and slides are prepared. The methodology is an adaptation of current CME procedures and medical economics to the familiar Clinico-Pathologic-Conference.

Appropriate means of evaluation of the program's effectiveness is by focused pre- and post-conference mini-audits. An effective program will require medical staff leadership, thoughtful planning, and a competent faculty who will use innovative methods to insure active participation from the physician audience. The CEC concept is adaptable to any size hospital, and to both inpatient and outpatient studies.

In conclusion, a combined cost-awareness and clinical efficacy program in the form of Clinico-Economic Conferences was instituted in a community hospital. Although evaluation is incomplete because of the newness of the program, it would appear that the CEC concept properly applied has the potential for considerable cost-saving as well as improvement in the quality of patient care. **OSMA**



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The OSMA House of Delegates

The 1980 OSMA Annual Meeting

Special Section

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Highlights of the 1980 OSMA Annual Meeting

May 10
thru
May 14

The Ohio State Medical Association's Annual Meeting is a time for honors, recognition, professional camaraderie, and perhaps most importantly, a chance to come together and discuss those issues that affect organized medicine and the future of health-care delivery in this country.

Through the OSMA's Annual Meeting, physicians have a chance to voice their concerns, express their feelings, and protect the interests of private practice, of patients, and the future of medicine.

This year's meeting was held May 10 through May 14 in Cincinnati, Ohio. The following pages bring you highlights of the meeting as Our Society Moves Ahead into the 1980s.



Radio personality J. Hugh Lutton (left) tapes an interview with Herman Abromowitz, M.D., Councilor from the Second District.

Sunday

It was a day for physicians to face the media, either in mock press conferences or bona fide radio interviews. The OSMA Department of Communications, in conjunction with Mortimer Enright of the American Medical Association, conducted an all-day "Media Training Seminar." The seminar allowed physicians a chance to brush up on their speaking skills, while showing them through mock interviews, press conferences, and talk shows the best way to get medicine's message to the public via the media. Meanwhile, in a small studio just outside the press room other physicians were being interviewed on topical medical issues by WLQA-FM radio's J. Hugh Lutton. Each interview was taped and sent to the radio station in the physician's hometown for air play later in the week.

Sunday night

The First Session of the House of Delegates was convened by OSMA President, Thomas Morgan, M.D.

Among the honored guests attending that first session was the celebrated physician, Albert B. Sabin, M.D., who developed the oral vaccine for polio. During the evening's proceedings, Dr. Sabin was presented with the 1980 OSMA Distinguished Service Citation by AMA's 1980 Distinguished Service Award recipient, Frank Mayfield, M.D., Cincinnati.



Respected . . .



Honored . . .



*The incomparable
Albert B.
Sabin, M.D.*

Honors and recognition did not stop there. A special Communications Award was presented to Albert Thielen, M.D., a Cincinnati physician who for the past 20 years has hosted the television program, "Call the Doctor." Mr. George Winters, the show's producer, was on hand to receive recognition from the OSMA on behalf of WCPO-TV, which has broadcast the program since 1960. Certificates of Appreciation were presented by Dr. Morgan to members retiring from OSMA Council, the AMA Delegation, and as chairpersons of various OSMA Committees. Philip Hardyman, M.D., Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF), and Mrs. Monica Kaye, now past president of the Women's Auxiliary, presented AMA-ERF checks to representatives of medical colleges from around the state.



Mr. George Winters (left) and Albert Thielen, M.D., Cincinnati, receive a Special Communications Award for 20 years of "Call the Doctor."



Retiring membership chairman, William R. Schultz, M.D., Wooster, is presented with a plaque recognizing his service by President Thomas A. Morgan, M.D.



John H. Budd, M.D., Cleveland, AMA past president, addresses the delegates.



Richard L. Meiling, M.D., Columbus, reads a memorial resolution to the House.

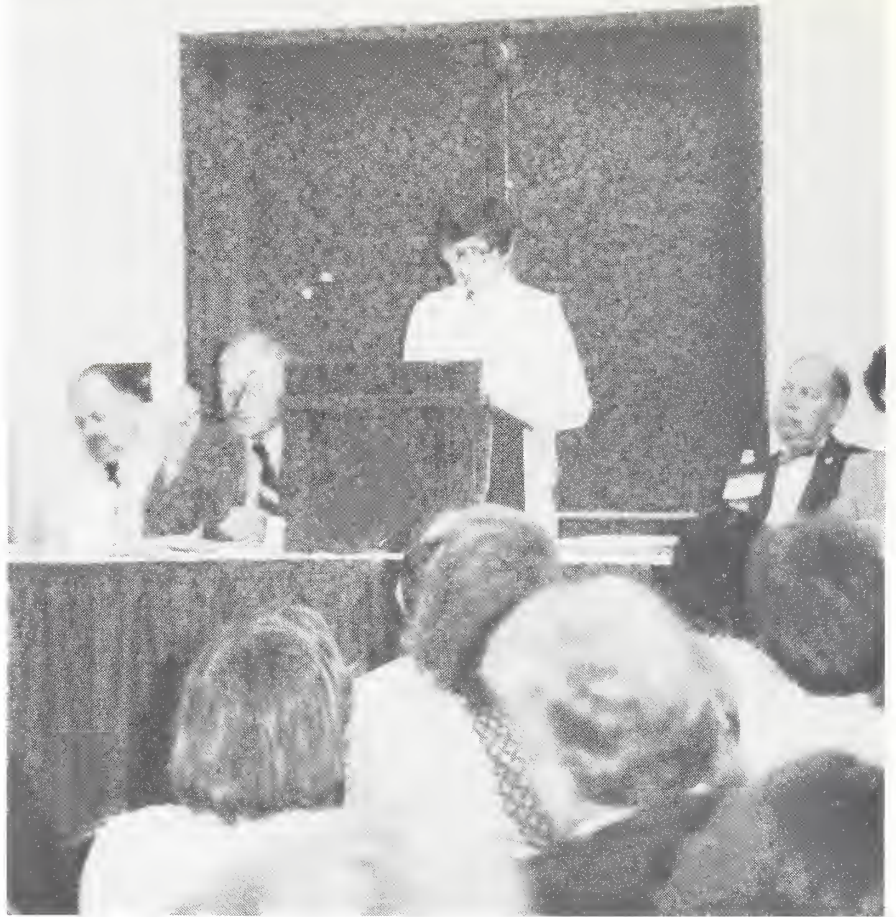


Philip Hardyman, M.D., and Auxiliary past president, Monica Kaye, distribute AMA-ERF checks.

Monday

Reference committees held hearings on the resolutions which had been assigned to them; doors to the scientific exhibit and resource center were opened; and several specialty societies met for luncheons and educational programs. The day's highlight was a Category II program entitled "Medicine and Nursing — Can We Work Together?"

The program, sponsored by the OSMA Committee on Health Manpower and the Ohio Nurses Association (ONA), presented both sides of the question. OSMA President, Dr. Thomas Morgan, spoke on "Nursing from the Physician's Viewpoint," and ONA President, Gertrude Torres, R.N., addressed the subject "Medical Practice from the Nurse's Viewpoint." A reactor panel, and questions and answers followed.



Gertrude Torres, R.N., presents an overview of medical practice from the nurse's viewpoint.

cluded on the program's panel were (left to right): Bobbie S. Nolan, R.N., Dayton; Beryl ott, Chickarella, R.N., Columbus; and C. Edward Pichette, M.D., of Youngstown.

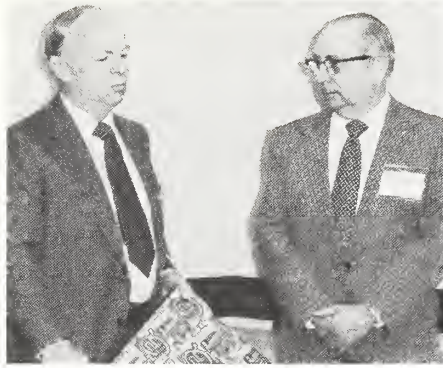


William M. Wells, M.D., Newark, moderated the program.

Tuesday



OSMA Executive Director, Hart Page, presents gifts to retiring County Society executives Mrs. Willadean Mitchell and Mr. Howard Rempes.



Jerry L. Hammon, M.D., West Milton (left) presents a plaque to H. W. Riemenschneider, M.D., Columbus, for his outstanding scientific exhibit.

H.W. RIEMENSCHNEIDER. M



Another day of recognition and honors. A special breakfast was held to honor retiring county medical society executives, Mrs. Willadean Mitchell of Montgomery County, Mrs. Marge McLaren of Lake County, and Mr. Howard Rempes of Mahoning County. More specialty societies met; Washington columnist, Robert Novak spoke at the OMPAC Luncheon; while down the hall at the sports medicine luncheon, awards were presented to Sol Maggied, M.D., West Jefferson for "outstanding contributions to sports medicine" from the Ohio Association for Health, Physical Education, Recreation and Dance; and to Richard F. Slager, M.D., of Columbus, past chairman of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association.

Scientific exhibitors also saw the limelight as they were presented with plaques for outstanding exhibits.



Brady F. Randolph, Jr., M.D., Hamilton (left), incoming chairman of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, presents a plaque to outgoing Chairman, George D. Bates, right, commissioner of the OHSAA.

Wednesday night

The final business session of the OSMA House of Delegates was convened by Dr. Morgan.

Harry Hines, M.D., Cincinnati, presented winners of the OSMA *Journal's* photographic contest with plaques for their outstanding entries. Reference committees presented their recommendations on the resolutions which had been assigned to them, and the House acted on their recommendations.

Highlighting the evening was the installation of OSMA's new president and the naming of the new president-elect.



Members of the House of Delegates assemble for the final business session.



Oscar W. Clarke, M.D., Gallipolis, keeps track of the action taken on resolutions.



Delegates listen to a report from a resolutions committee.



The Robert Thomas family.



John Gaughan, M.D., presents the President's medallion to Dr. and Mrs. Thomas Morgan



OSMA's new President, Robert G. Thomas, M.D., Elyria.

In inaugural ceremonies, Robert G. Thomas, M.D., and his family were escorted to the podium where Dr. Thomas took the presidential oath of office, administered by 1979-1980 past president, John Gaughan, M.D. Dr. Thomas then addressed the House and introduced the members of his family.

Prior to Dr. Thomas' inauguration, Dr. and Mrs. Thomas Morgan received the president's medallion from Dr. Gaughan, and Dr. Morgan was presented with the past president's plaque.

Earlier in the evening Stewart B. Dunsker, M.D., Cincinnati, was named OSMA's president-elect. **OSMA**



President-Elect Stewart B. Dunsker, M.D., Cincinnati.

"THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

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What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977 "Face-Off: Cost Containment vs. Chaos," January 1, 1977

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.

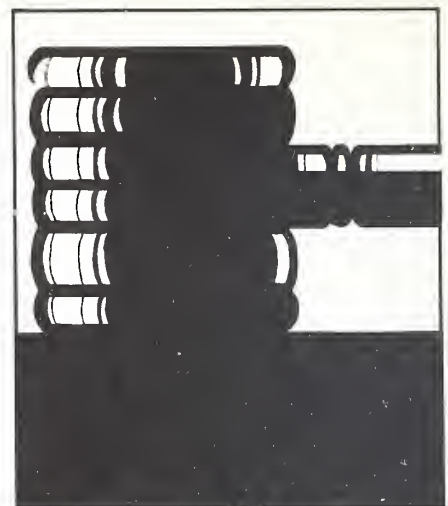


INDEX TO ACTIONS ON RESOLUTIONS

Editor's Note: Report of Resolutions Committee No. 1 begins on page 425; Resolutions Committee No. 2 on page 428; Resolutions Committee No. 3 on page 432. This index is for reference purposes and is not part of the Official Proceedings of the 1980 House of Delegates.

RESOLUTION NO . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE
01	Principles of Medical Ethics (Stark County Medical Society)	1
02	Principles of Medical Ethics (Academy of Medicine of Cleveland)	1
03	Principles of Medical Ethics (Fifth District Delegation)	1
04	Repeal of AMA Policy Regarding Interest on Unpaid Accounts (Fifth District Delegation)	1
05	Continuing Medical Education in Ohio (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	1
06	Accreditation of CME Programs (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	1
07	Mandatory Continuing Medical Education (Ross County Medical Society)	1
08	Ohio State Medical Association Responsibility for Continuing Education (Academy of Medicine of Cincinnati)	1
09	Funding for the Ohio State Medical Board (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	1
10	Definition of Death (OSMA Council)	1
11	Determination of Death (Academy of Medicine of Cincinnati)	1
12	Mandatory Living Will Proposals (Fifth District Delegation)	1
13	Informed Consent Concerning Abortion (Joseph Schultz, M.D., Alternate Delegate, Cuyahoga County)	1
14	Commendation to 11th District Councilor Baird Pfahl, M.D. (Huron County Medical Society)	1
15	Promoting and Strengthening Freedom for All — The Americanism Foundation (Huron County Medical Society)	1
16	C.T. Scanning (Ross County Medical Society)	1
*17	P. John Robeck, M.D., Memorial Resolution (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	1
*18	George W. Petznick, M.D., Memorial Resolution (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	1
19	Implementation of Report G. of the AMA (Fifth District Delegation)	2
20	Public Relations (Huron County Medical Society)	2
21	Facilitating and Encouraging Communications (Huron County Medical Society)	2
22	Letters to the Editor of the Ohio State Medical Association (Second Councilor District)	2
23	Proposed Amendment to the Bylaws to Define Valid Ballots in Elections (OSMA) Council	2
24	Establishment of Councilor Districts (OSMA Council)	2
25	Representation of Specialty Societies in OSMA Delegations (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	2
26	Medical Specialty Representation in OSMA House of Delegates (OSMA Council)	2
27	Specialty Society Representation in OSMA (Academy of Medicine of Cincinnati)	2
28	Semiannual Meetings of OSMA House of Delegates (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	2
29	Interim Sessions of the OSMA House of Delegates (Sixth District Delegation)	2
30	Mothers Day/Annual Meeting (Sixth District Delegation)	2
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32	Annual Meeting Timetable (Summit County Medical Society)	2
33	Proposed Amendment to the Bylaws to Change Titles of the Standing Committees (OSMA Council)	2
34	Voting for AMA Delegates and Alternate Delegates (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	2
35	Full Voting Privileges for Medical Students and Residents (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	2
36	Election of Officers (John H. Boyles, Jr., M.D., Delegate, Montgomery County)	2
37	Participation in Organized Medicine (Peter A. Overstreet, M.D., Delegate, Lucas County)	2
38	Single Membership for Organized Medicine (Fifth District Delegation)	2
39	Limitation of Service on AMA Delegation (Academy of Medicine of Cleveland)	2
40	AMA Membership (Summit County Medical Society)	2
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42	Site of Council Meetings (John H. Boyles, Jr., M.D., Delegate, Montgomery County)	2
43	Physician Population in the United States (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	3
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47	Disaster Services Agency (Emergency Medical Services) (Fifth District Delegation)	3
48	Categorization of Hospital Facilities for Emergency Medical Services (Frank E. Foss, M.D., Delegate, Lucas County)	3
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51	Reaffirmation of Existing Policy (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	3
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53	Medical Release Form (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	3
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61	Elimination of Economic Discrimination Against Patients in Community Hospitals Concerning Compensation for In-Hospital Physician Services (Fifth District Delegation)	3
62	Equitable Risk Classifications in Medical Liability Premiums (Academy of Medicine of Columbus & Franklin County)	3
63	PICO Professional Liability Insurance (Academy of Medicine of Cleveland) (Endorsed by Fifth District Delegation)	3
64	Reimbursement of Crippled Children's Services Withdrawn (Robert S. Heidt, M.D., Secretary-Treasurer, Ohio Orthopaedic Society)	
65	Mental Health Coverage by Physician-Sponsored Health Care Plans (Max D. Graves, M.D., Clark County)	3
66	Establishment of a Liaison Committee for Communication and Interaction with the EPA and with State County Health Commissioners (Sandusky County Medical Society)	2



council proceedings

PROCEEDINGS OF THE COUNCIL

May 15, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Thursday, May 15, 1980, at Stouffer's Cincinnati Towers, Cincinnati.

Those present were:

Robert G. Thomas, M.D., Elyria
Stewart B. Dunsker, M.D., Cincinnati
Thomas W. Morgan, M.D., Gallipolis
David A. Barr, M.D., Lima
John E. Albers, M.D., Cincinnati
Herman I. Abromowitz, M.D., Dayton
Alford C. Diller, M.D., Van Wert
C. Douglass Ford, M.D., Toledo
Edward G. Kilroy, M.D., Cleveland
Joseph P. Yut, M.D., Canton
H. Judson Reamy, M.D., New

Philadelphia

Carl E. Spragg, M.D., New Concord
A. Burton Payne, M.D., Ironton
J. Hutchison Williams, M.D., Columbus
S. Baird Pfahl, Jr., M.D., Sandusky
William Dornier, Jr., M.D., Akron
James E. Pohlman, Esq., Columbus
Robert N. Smith, M.D., Toledo
Members of the OSMA Executive Staff
Dr. Thomas introduced the new
Councilor from the First District, Dr. John
E. Albers, Cincinnati.

Dr. Thomas then commended Dr. Morgan on the culmination of his presidency, during which his skill as the presiding officer resulted in well-organized, efficient, and orderly sessions of the House of Delegates. Dr. Morgan received the applause of the Council.

By official action, Dr. Thomas was authorized to vote the Class B stock of PICO owned by the Ohio State Medical Association at the May 15, 1980 annual meeting of the shareholders of the Physicians Insurance Company of Ohio.

Dr. Thomas presented his committee appointments for 1980-1981 and they were duly ratified by the Council.

ATTEST: Hart F. Page, CAE
Executive Director

The Ohio State Medical Journal

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Minutes of the First Session, House of Delegates

PROCEEDINGS OF THE OSMA HOUSE OF DELEGATES ASSEMBLED AT THE 1980 ANNUAL MEETING

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Sunday, May 11, 1980, at Stouffer's Cincinnati Towers, Cincinnati, with President Thomas W. Morgan, M.D., presiding.

The Invocation was offered by Ronald K. Marmaduke, Senior Minister, First Congregational Church, Elyria.

Dr. Morgan introduced James L. Golden, Ph.D., Director of Communications, The Ohio State University, the parliamentarian retained in accordance with Resolution No. 1-76.

Dr. Richard B. Budde, Cincinnati, President of the Academy of Medicine of Greater Cincinnati, welcomed the delegates and guests to Cincinnati.

REPORT ON DELEGATES PRESENT

Dr. William E. Sovik, Poland, Chairman of the Credentials Committee, reported that of 186 members eligible to attend and vote, 157 were present, credentialed and seated. A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

1979 MINUTES APPROVED

The minutes of the 1979 sessions of the House of Delegates, as published in the July 1979 issue of *The Ohio State Medical Journal*, were approved by official action.

INTRODUCTION OF AMA BOARD OF TRUSTEES MEMBER

Dr. Morgan then introduced Dr. H. Thomas Ballantine, Jr., Boston, Massachusetts, AMA Trustee and candidate for President-Elect of the American Medical Association. Dr. Ballantine addressed the House.

INTRODUCTION OF MEMBER OF THE AMA AD HOC COMMITTEE ON THE PRINCIPLES OF MEDICAL ETHICS

Dr. Carroll Witten, Louisville, Kentucky then was introduced by Dr. Morgan. Dr. Witten reported on the progress of the Ad Hoc Committee on the Principles of Medical Ethics of the American Medical Association.

INTRODUCTION OF OUT-OF-STATE GUESTS

Dr. Morgan introduced Dr. Richard J. Menke, Crestview Hills, Kentucky, Vice President of the Kentucky Medical Association, and Dr. Leroy A. Gehris, Reading, Pennsylvania, President-Elect of the Pennsylvania Medical Society.

July 1980

INTRODUCTION OF REPRESENTATIVES OF ALLIED ORGANIZATIONS

Dr. Morgan introduced the following representatives of allied organizations: Dr. Jack W. Gottschalk, President, Ohio Dental Association; Walter A. Mischley, Chairman of the Board, Ohio Hospital Association; Dr. Donald L. Turner, President, Ohio Osteopathic Association; Dr. Stanley T. Pinsky, President, Ohio State Radiological Society; Dr. Oliver K. Roth, President-Elect, Ohio Academy of Family Physicians; Mrs. Joel E. Kaye, President and Mrs. Sam I. Sato, President-Elect, Ohio State Medical Association Auxiliary.

INTRODUCTION OF OSMA PAST PRESIDENTS

The following past presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Bratenahl; Dr. Richard L. Meiling, Columbus; Dr. Frank H. Mayfield, Cincinnati; Dr. Edwin H. Artman, Waverly; Dr. Lawrence C. Meredith, Oberlin; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. William R. Schultz, Wooster; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. George N. Bates, Toledo; Dr. William M. Wells, Newark; and Dr. John J. Gaughan, Cleveland.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Morgan then introduced former members of the Council: Dr. Philip B. Hardyman, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. W. J. Lewis, Dayton; Dr. James C. McLarnan, Mt. Vernon; Dr. Paul F. Orr, Perrysburg; Dr. C. Edward Pichette, Youngstown; and Dr. George J. Schroer, Ft. Loramie.

OTHER GUESTS INTRODUCED

Dr. Morgan introduced the following: Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Mr. Gary L. Lessman, Chicago, Illinois, Office of Medical Society Relations of the AMA.

He also introduced Dr. John H. Budd, Cleveland, Past President of the American Medical Association, who, in turn, gave a short address to the House.

PICO REPORT

Dr. Morgan then introduced Dr. George N. Bates, Toledo, Chairman of the Board of Trustees, Physicians Insurance Company of Ohio. Dr. Bates gave a report on the current status of the company and a summary of the activities and accomplishments of PICO in 1979.

REPORT OF OSMA AUXILIARY PRESIDENT

Mrs. Joel E. Kaye, Mansfield, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. James W. Wiggins, a Delegate from Richland County. She addressed the House of Delegates and reported on 1979 activities of the Auxiliary. The theme of her address was "Friendship Through Progress."

INTRODUCTION OF RESOLUTION ON DR. SABIN

Dr. Morgan read the following resolution on Dr. Albert B. Sabin to the House of Delegates:

WHEREAS Albert B. Sabin, M.D., has distinguished himself as one of the great scientists of medicine and WHEREAS Dr. Sabin, through his brilliant research produced the key to lifelong immunity to polio thus sparing untold millions of human beings throughout the world the pain and suffering of polio and

WHEREAS Dr. Sabin has dedicated his life to protecting and improving the health of all peoples of the world, now therefore be it

RESOLVED, that the Ohio State Medical Association expresses its deepest respect and admiration to Dr. Sabin for his untiring efforts and the many contributions that he has made to medicine and to the world.

The resolution was adopted by the House of Delegates by a rising vote.

INTRODUCTION OF THE RECIPIENT OF THE AMA 1980 DISTINGUISHED SERVICE AWARD

Dr. Morgan introduced Dr. Frank H. Mayfield, Cincinnati, the recipient of the AMA 1980 Distinguished Service Award. He will receive this award at the AMA Annual Meeting, in July.

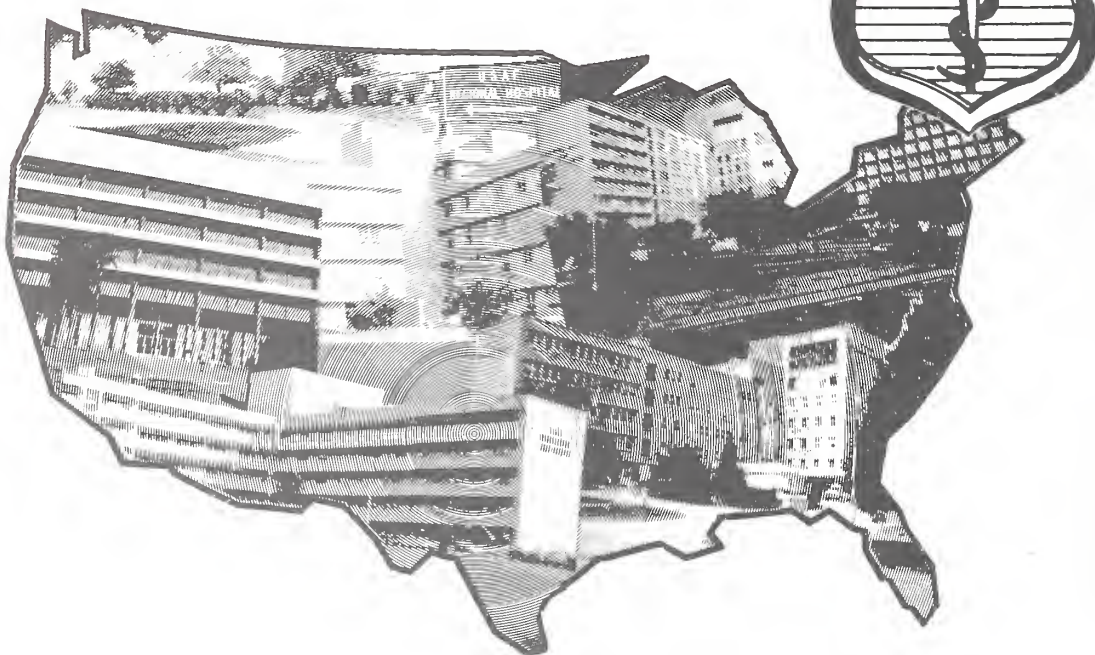
PRESENTATION OF THE OSMA 1980 DISTINGUISHED SERVICE AWARD

Dr. Frank H. Mayfield escorted Dr. Albert B. Sabin and Mrs. Sabin to the podium where he presented Dr. Sabin with a plaque. Dr. Sabin addressed the House and expressed his thanks and appreciation.

PRESENTATION OF A SPECIAL COMMUNICATIONS AWARD

Dr. Morgan introduced Dr. Albert Thielen, Cincinnati, and Mr. George Winters, Television Station WCPO, and asked that they come forward. A special Communications Award was given to Dr. Thielen for his service as host of the weekly television program, "Call the Doctor." An award was also presented to Mr. Winters for his participation in the program as its producer.

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TSgt William A. Agnew
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Minutes of the First Session (continued)
AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced, as was Mrs. Monica Kaye, President of the OSMA Auxiliary. Mrs. Kaye assisted Dr. Hardymon in the presentation of the AMA-ERF checks as follows:

• To Dr. Frederick T. Suppes, of the Alumni Association, Case Western Reserve University School of Medicine, Cleveland: \$11,373.71.

• To Dr. J. Hutchison Williams, Associate Dean, The Ohio State University College of Medicine, Columbus: \$20,159.01.

• To Dr. Eugene Jacobson, Associate Dean, University of Cincinnati College of Medicine, Cincinnati: \$16,586.37.

• To Dr. John P. Kempf, Dean of the Medical Faculty, Medical College of Ohio at Toledo, Toledo: \$5,116.50.

• To Dr. Robert A. Liebelt, Provost & Dean, Northeastern Ohio Universities College of Medicine, Kent: \$4,554.25.

• To Dr. John R. Beljan, Vice President of Health Affairs & Dean, Wright State University School of Medicine, Dayton: \$4,763.45.

It was announced that these contributions totalled \$62,553.29. Dr. Morgan expressed thanks on behalf of the Association to Dr. Hardymon and to the OSMA Auxiliary for its usual hard work in making this campaign a success.

CERTIFICATES OF APPRECIATION

Dr. John J. Gaughan, Cleveland, and Dr. W. J. Lewis, Dayton, received plaques in appreciation of their service to the Association as retiring members of the Council. Dr. Lewis also received a plaque as retiring member of the AMA Delegation (Delegate).

The following retiring committee chairmen received certificates of appreciation: Dr. J. Hutchison Williams, Columbus, Ad Hoc Committee on Auditing and Appropriations; Dr. Alford C. Diller, Van Wert, OSMA Auxiliary Advisory Ad Hoc Committee; Dr. William R. Schultz, Wooster, Committee on Membership; Dr. Robert E. Schulz, Wooster, Committee on Laboratory Medicine; Dr. Richard F. Slager, Columbus, Joint Advisory Committee on Sports Medicine; Dr. C. Douglass Ford, Toledo, Committee on State Legislation; Dr. Oscar W. Clarke, Gallipolis, Committee on Private Practice and Patient Care; and Dr. Robert E. Reiheld, Orrville, Committee on Rural Health.

REFERENCE COMMITTEES APPOINTED

The following House of Delegates Reference Committee chairmen were appointed and introduced by the President:

Credentials of Delegates — Dr. William E. Sovik, Mahoning County; *Tellers and Judges of Election* — Dr. James B. Daley, Cuyahoga County; *President's Address* — Dr. John H. Budd, Cuyahoga County; *Resolutions Committee No. 1* — Dr. Thomas P. Price, Jr., Gallia County; *Resolutions Committee No. 2*

— Dr. A. Robert Davies, Miami County; *Resolutions Committee No. 3* — Dr. Richard J. Nowak, Cuyahoga County.

Two changes in Resolutions Committee personnel were announced as follows: Dr. Frederic C. Schnebly, Montgomery County, Committee No. 2; and Dr. Manley L. Ford, Summit County, Committee No. 3.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: *First District* — Dr. Robert S. Heidt, Hamilton County; *Second District* — Dr. Isador Miller, Champaign County; *Third District* — Dr. Robert B. Elliott, Hardin County; *Fourth District* — Dr. Robert J. Blough, Henry County; *Fifth District* — Dr. Edward G. Kilroy, Cuyahoga County; *Sixth District* — Dr. Raymond J. McMahon, Jr., Stark County; *Seventh District* — Dr. Philip T. Doughten, Tuscarawas County; *Eighth District* — Dr. John P. Anderson, Jr., Licking County; *Ninth District* — Dr. A. Burton Payne, Lawrence County; *Tenth District* — Dr. James E. Matson, Franklin County; *Eleventh District* — Dr. A. Burney Huff, Wayne County; and *Twelfth District* — Dr. Paul D. Gatewood, Summit County.

Dr. Morgan announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Seventh District, Dr. Philip T. Doughten, Tuscarawas County.

INTRODUCTION OF RESOLUTIONS

Dr. Morgan said that because the resolutions had been printed and distributed prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented to the House in writing, he would not introduce them one by one unless there were objections voiced by the House.

It was noted that one resolution, Resolution No. 64-80, "Reimbursement of Crippled Children's Services," was withdrawn prior to meeting time.

COMMITTEE ON EMERGENCY RESOLUTIONS REPORT

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met earlier on May 11 to consider two emergency resolutions: one submitted by W. W. Tuckerman, M.D., Delegate, Cuyahoga County regarding CME; and the other, submitted by the Sandusky County Medical Society regarding the EPA. Dr. Thomas P. Price, Jr., Chairman, advised the House that the Committee accepted only the resolution submitted by the Sandusky County Medical Society as an emergency resolution and it was assigned to the Resolutions Committee No. 2, as Resolution No. 66-80.

INTRODUCTION OF MEMORIAL RESOLUTIONS

The following memorial resolutions were introduced:

MEMORIAL RESOLUTION

P. John Robeck, M.D. Submitted by: Academy of Medicine of Cleveland, Endorsed by: Fifth District Delegation. Introduced on the floor of the House by Dr. John J. Gaughan.

WHEREAS, P. John Robeck, M.D.

served this community faithfully and well during his thirty-nine years as a physician and surgeon, and

WHEREAS, Dr. Robeck served his fellow physicians and the medical profession with devotion and excellence through his work on many medical society committees of the Academy of Medicine of Cleveland, the Ohio State Medical Association, and

WHEREAS, Dr. Robeck served as President of the Academy of Medicine of Cleveland and President of the Ohio State Medical Association, and

WHEREAS, Dr. Robeck was a delegate from Ohio to the American Medical Association, and

WHEREAS, Dr. Robeck was awarded Distinguished Membership in the Academy of Medicine of Cleveland in 1975, the Academy's highest honor, and

WHEREAS, Dr. Robeck was widely respected and honored as a leader in medical, civic and cultural activities, NOW THEREFORE BE IT RESOLVED,

That the Ohio State Medical Association expresses its sincere appreciation and admiration for Dr. Robeck's many contributions during his lifetime and extends its deepest sympathy to Ruth Robeck and her family.

MEMORIAL RESOLUTION

George W. Petznick, M.D. Submitted by: Academy of Medicine of Cleveland. Endorsed by: Fifth District Delegation. Introduced on the floor of the House by Dr. John H. Budd.

WHEREAS, George W. Petznick, M.D., exemplified the highest traditions of the medical profession during his fifty years as a physician, and

WHEREAS, Dr. Petznick served the American Medical Association as a delegate for Ohio and as Chairman of the Judicial Council, and

WHEREAS, Dr. Petznick served the Ohio State Medical Association as Fifth District Councilor and as President, and

WHEREAS, Dr. Petznick, in recognition of his services to the medical profession was awarded the Distinguished Membership, the Academy's highest honor.

NOW THEREFORE BE IT RESOLVED, That the OSMA honors George W. Petznick, M.D. for his services and contributions during his lifetime and extends its deepest sympathy to Jean Petznick and her family.

MEMORIAL RESOLUTION

Robert S. Martin, M.D. Submitted by:
Muskingum County Medical Society.

Introduced on the floor of the House by
Dr. Richard L. Meiling.

WHEREAS, Robert S. Martin, M.D.,
1894-1979, served his communities and
his fellow man well, faithfully and
honorably during his sixty years as a
physician and surgeon, having received
his M.D. degree from the University of
Cincinnati in 1919 and

WHEREAS, Dr. Martin served as
President of the Ohio State Medical
Association 1957-1958, Councilor of the
Eighth District for many years, and
member of the Ohio Delegation to the
American Medical Association and
served as a member of the Board of
Governors of the American College of
Surgeons and as President of the
Muskingum County Medical Society
and

WHEREAS, Dr. Martin as a civic leader
served as President of the Rotary Club
of Zanesville and for thirteen years as a
member of the Board of Directors of
the First National Bank of Zanesville.
He also served on the Board of
Directors of the Ohio Medical
Indemnity Company and the Board of
the Medical Indemnity of America and

WHEREAS, Dr. Martin as an educator
and humanitarian served on the Board
of Trustees (and as its chairman) of the
Muskingum College and

WHEREAS, Dr. Martin was respected
and honored by his medical colleagues,
acknowledged a leader by his fellow
citizens of his community and state,
and had served as a patriotic defender
of his nation in time of war.

NOW THEREFORE BE IT RESOLVED,
That the Ohio State Medical
Association expresses its recognition of
Dr. Martin's contributions to his
country, his state, his community, his
profession and his fellow citizens

during his lifetime and extends its
deepest sympathy to his widow, Rachel
Cowden Martin, and his daughter,
Rachel Bess (Martin) Geiger.

MEMORIAL RESOLUTION

A. A. Brindley, M.D. Submitted by:
Academy of Medicine of Toledo and Lucas
County. Introduced on the floor of the
House by Dr. Robert N. Smith.

WHEREAS, Dr. A. A. Brindley was an
outstanding citizen of this community,
participating actively and effectively in
both civic and medical areas during his
many years in general medicine and
anesthesiology, and

WHEREAS, Dr. Brindley served his
fellow physicians with his excellent
participation on various medical
committees and ultimately as President
of The Academy of Medicine of Toledo
and Lucas County, and

WHEREAS, Dr. Brindley, in esteemed
recognition, was elevated by his peers
to the Presidency of the Ohio State
Medical Association which office he
executed admirably and
enthusiastically, and

WHEREAS, Dr. Brindley was respected
by all who knew him as a
compassionate associate and a true
gentleman,

NOW THEREFORE BE IT RESOLVED,
That the Ohio State Medical
Association sincerely honors A. A.
Brindley, M.D. for these many
contributions to medicine and mankind
throughout his exemplary career and
extends deep sympathy to Katherine
Brindley and her entire family.

The resolutions were adopted by a
standing vote of the members of the House
of Delegates.

PRESIDENT'S ADDRESS

Mr. Page then introduced President
Thomas W. Morgan, Gallipolis, who
delivered his Presidential Address.

Dr. Morgan received a standing ovation.

REPORTS TO THE HOUSE OF DELEGATES

Dr. Morgan announced that the
following reports had been distributed to
the Delegates and Alternates prior to the
First Session: "Action Report on 1979
Resolutions," "President's Report on
Membership," "Treasurer's Report," and
"Legislation Department Report."

REPORT OF AD HOC COMMITTEE ON AMENDED RESOLUTION 19-79 UPDATE OF OSMA POLICY

Dr. Morgan introduced Dr. James C.
McLarnan, Mt. Vernon, Chairman of the
Ad Hoc Committee to Review OSMA
House of Delegates Policy. Dr. McLarnan
gave the report of the Committee.

Several deletions of resolutions covered
by the report were requested and approved
as follows:

Dr. Frederick T. Suppes asked for
deletion of Resolution 40-76, Determination
of Death.

Dr. Donavin A. Baumgartner, Jr., Am.
Substitute Resolution 30-77, Liability
Reform.

Dr. Stewart B. Dunsker, Substitute
Resolution on Universal Immunizations,
19-59, Amended Resolution No. 19-74,
Preadmission Certification; Amended
Resolution No. 42-76, Maximum Allowable
Cost Regulations; Substitute Resolution No.
23-77, Cost Containment; Government
Health Programs.

Dr. Sol Maggied asked for the floor to
express his sentiments to the Ad Hoc
Committee for a "job well done."

It was moved and seconded that the
report be approved. By official action, the
House voted to approve the Report of the
Ad Hoc Committee to Review OSMA
House of Delegates Policy.

HOUSE RECESSED

The House then recessed until the final
session, 3:30 PM, Wednesday, May 14.

What's in Chillicothe?

Besides great outdoor recreation opportunities
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need for emergency medicine physicians—to
provide emergency medical services to the 40,000
area residents of the Southeast Ohio city and
others living in the seven county area served by
the hospital.

There are also excellent schools in Chillicothe,
and a new 250 bed hospital with some 30,000 ED
visits a year.

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Dayton—an hour and a half east. Kentucky and
West Virginia—they're close by too.

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condusive to a good personal as well as profes-
sional lifestyle.

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OSMA's new president-elect

The Ohio State Medical Association is proud to welcome Stewart B. Dunsker, M.D., as the Association's new president-elect.

Dr. Dunsker, a neurosurgeon from Cincinnati, has been an active member of the OSMA, AMA, and various neurosurgical societies for many years.

A cum laude graduate of Harvard College, Dr. Dunsker graduated from the University of Cincinnati College of Medicine in 1960. He presently serves as clinician in neurosurgery at the University, in addition to holding various positions in resident and graduate training programs at two Cincinnati hospitals.

In society activities, Dr. Dunsker is a past secretary of the Cincinnati

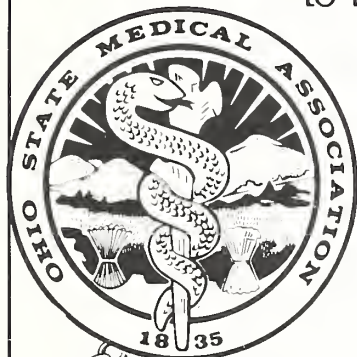
Academy of Medicine, and has been serving the OSMA as First District Councilor since 1977. Twice a delegate from the First District to OSMA Annual Meetings, Dr. Dunsker also has been active on many OSMA committees, including the State Legislative Committee, the Task Force on Professional Liability, and the Public Relations Committee. He also serves as an alternate delegate to the AMA.

In his specialty societies, Dr. Dunsker chairs the Legal Affairs Committee of the Ohio State Neurosurgical Society, is active in the Congress of Neurological Surgeons, and is serving as this year's president of the Society of University Neurosurgeons.



Stewart B. Dunsker, M.D.

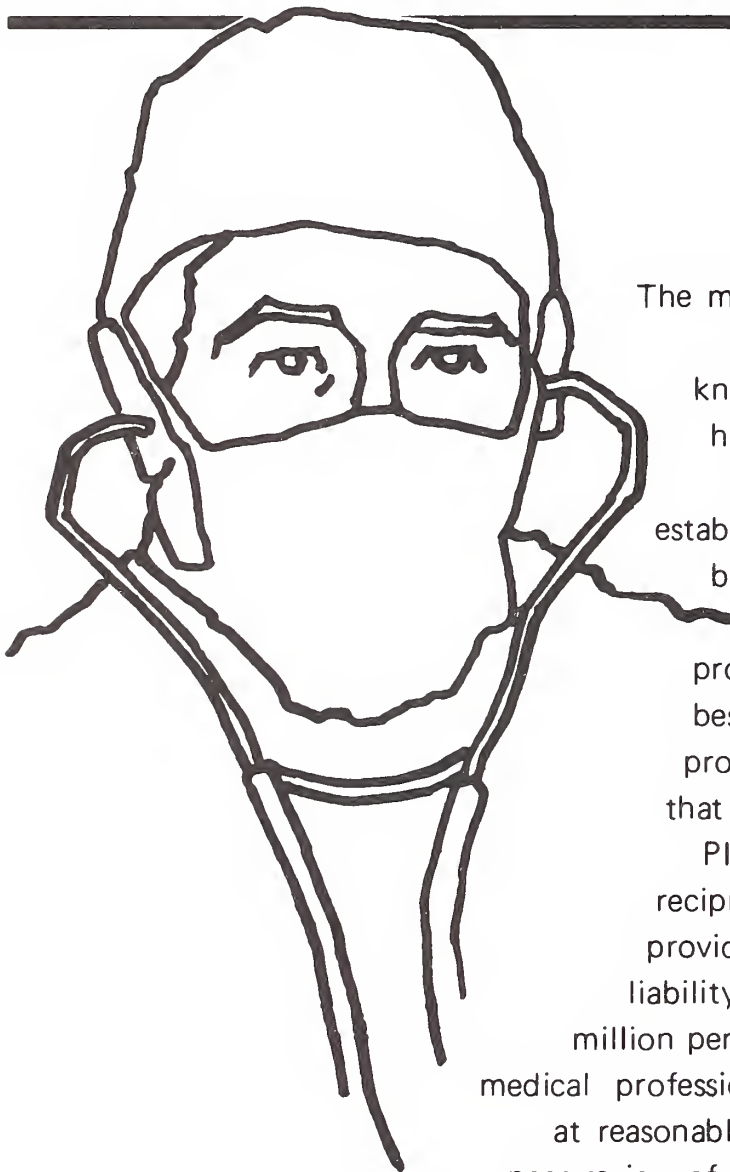
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Minutes of the Second Session, House of Delegates

Minutes of the Second Session

The final business session of the House of Delegates convened at 3:30 PM, Wednesday, May 14, at Stouffer's Cincinnati Towers, Cincinnati, with President Thomas W. Morgan, M.D., presiding.

The House directed the President to send a letter of commendation to the University of Cincinnati singers for their outstanding performance at the previous evening's social program and a letter of appreciation to the members of the Auxiliary for their assistance in this program.

INTRODUCTION OF OUT-OF-STATE GUESTS

Dr. Morgan introduced Dr. Stephen Ward, Wheeling, West Virginia, President of the West Virginia State Medical Association, and Dr. Leroy A. Gehris, Reading, Pennsylvania, President-Elect of the Pennsylvania Medical Society, and Mrs. Gehris.

INTRODUCTION OF OSMA STAFF MEMBERS

Dr. Morgan announced the affiliation in national organizations of: Hart F. Page — President, American Association of Medical Society Executives; and Jerry J. Campbell, President-Elect, Professional Convention Management Association.

He also complimented Mrs. Gail Dodson and Dave Torrens for their excellent performance in arranging the 1980 Annual Meeting.

PRESENTATION OF PHOTOGRAPHIC AWARDS

The 1980 Ohio State Medical Journal Photographic Exhibit awards were presented by Dr. Harry K. Hines, Chairman of the Journal Photographic Exhibit Award Committee, to the following:

Best in Show — Vera Kalnins, Bucyrus, "Strawberries."

Outstanding Entries — Dr. James Rudick, Canton, "Canadian Sunset"; Dr. George Morrice, Newark, "Braille Medical Text"; Dr. Joseph M. Wilson, Dayton, "Autumn Reflections"; Dr. George W. Waylonis, Columbus, "Storm Clouds"; Dr. O. David Solomon, Shaker Heights, "Mosai Infant and Mother"; Dr. Lewis W. Coppel, Chillicothe, "Colorado Moonshine"; Vera Kalnins, Bucyrus, "Frost"; Dr. Warren W. Smith, Columbus, "Pelicans Key West"; Dr. Edward Kezur, Hamilton, "Brief Moments"; Dr. John C. Starr, London, "Jack Frost's Magic"; and Jessica M. Mader, Silver Lake, "Peninsula Post Office."

After the presentations, Dr. Hines thanked and named members of the committee and members of the staff, Ms. Doll and Ms. Edwards.

Dr. Morgan then presented to Dr. Hines a plaque from the Association in appreciation to him for serving as chairman of the committee.

July 1980

COMMITTEE ON TELLERS AND JUDGES OF ELECTION

Dr. Morgan named Dr. Charles P. Bartley, Cuyahoga County, and Dr. John H. Flora, Champaign County, to serve on the Committee on Tellers and Judges of Election.

REPORT OF CREDENTIALS COMMITTEE

Dr. William E. Sovik, Poland, Chairman of the Committee on Credentials, reported that out of 186 delegates eligible to vote, 166 were present, credentialed and seated.

ELECTION OF PRESIDENT-ELECT

Dr. Morgan called for nominations for the office of President-Elect.

Dr. John E. Albers, Cincinnati, placed in nomination Dr. Stewart B. Dunsker, Cincinnati, Hamilton County. The nomination was seconded by Dr. Theodore J. Castele, Cleveland. Dr. Homer A. Anderson, Columbus, placed in nomination Dr. J. Hutchison Williams, Columbus, Franklin County. The nomination was seconded by Dr. B. Leslie Huffman, Jr., Maumee. There were no other nominations and Dr. Dunsker was elected on the first ballot.

REPORT OF NOMINATING COMMITTEE

Dr. Philp T. Doughten, Delegate, Tuscarawas County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations, as follows:

Councilor

First District: As Councilor of the First District to succeed Dr. Stewart B. Dunsker, the Committee placed in nomination Dr. John E. Albers, Cincinnati. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Albers was declared elected Councilor of the First District for a term of two years, 1980-1982.

Third District: As Councilor of the Third District to succeed himself, the Committee placed in nomination Dr. Alford C. Diller, Van Wert. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Diller was declared reelected Councilor of the Third District for a term of two years, 1980-1982.

Fifth District: As Councilor of the Fifth District to succeed himself, the Committee placed in nomination Dr. Edward G. Kilroy, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Kilroy was declared reelected Councilor of the Fifth District for a term of two years, 1980-1982.

Seventh District: As Councilor of the Seventh District to succeed himself, the Committee placed in nomination Dr. H. Judson Reamy, New Philadelphia. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Reamy was declared reelected Councilor of the Seventh District for a term of two years, 1980-1982.

Ninth District: As Councilor of the Ninth District to succeed himself, the Committee placed in nomination Dr. A. Burton Payne, Ironton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Payne was declared reelected Councilor of the Ninth District for a term of two years, 1980-1982.

Eleventh District: As Councilor of the Eleventh District to succeed himself, the Committee placed in nomination Dr. S. Baird Pfahl, Jr., Sandusky. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Pfahl was declared reelected Councilor of the Eleventh District for a term of two years, 1980-1982.

Second District: As Councilor of the Second District to fill an unexpired term now held by Dr. Herman I. Abromowitz, the Committee placed in nomination Dr. Abromowitz, Dayton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Abromowitz was declared elected Councilor of the Second District for a term of one year, 1980-1982.

AMA Delegates

Dr. Doughten then presented the nominees for the office of Delegate to the American Medical Association for a term of two years beginning January 1, 1981 and ending December 31, 1982: Drs. Theodore J. Castele, Cleveland; Jerry L. Hammon, West Milton; H. William Porterfield, Columbus; Jack Schreiber, Canfield; and Robert N. Smith, Toledo. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Hammon, Porterfield, Schreiber and Smith were declared elected.

For Delegate to the American Medical Association to fill a vacancy immediately and to serve a one-year term beginning January 1, 1981 and ending December 31, 1981, the Nominating Committee placed in nomination the name of Dr. Richard L. Fulton, Columbus. The nomination was duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Fulton was declared elected.

Continued on page 425

Presidential Reflections

Editor's Note: The following text is taken from the address, given by then President Thomas Morgan, M.D., during the first session of the House of Delegates. Dr. Morgan raises a number of points which we felt was worth repeating.



Thomas Morgan, M.D.

It hardly seems possible that a year has passed since I last addressed this House at the beginning of a fascinating, occasionally frustrating, but ultimately rewarding year of stewardship of your State Medical Association.

Despite continuing disarray within our own household, we are able to report significant progress in combating the "instant doctor syndrome" and in slowing the intrusion of regulatory bodies such as the FTC into the medical arena. This optimistic turn of events owes its success to a vigorous effort by our legislative committee and staff, both AMA and OSMA.

During the past few months the OSMA has been able to thwart efforts to permit pharmacists to administer drugs and redefine the practice of pharmacy to increase responsibility of the pharmacist in patient drug selection. We have again successfully opposed the bill that would allow optometrists to use drugs on their patients. Most importantly, the OSMA

successfully stopped an attempt in HB 753 (hospital licensure) to grant psychologists, podiatrists, and physical therapists independent hospital admitting privileges without physician supervision.

Surcharge eliminated

Of particular significance to all Ohio physicians, whether OSMA members or not, was the successful effort to rewrite part of the recent JUA-SRF bill to eliminate the \$250 surcharge placed by the legislature on every physician's malpractice insurance premium since 1975. This provision alone will save Ohio physicians over \$3 million in 1980 and every year thereafter. In addition the OSMA helped draft language that requires the return of the previous SRF assessments to physicians and hospitals who paid them, a provision worth over \$20 million.

Just when we thought passage of this legislation assured the return of SRF monies on schedule, certain questions regarding various forms of potential liability involving the SRF were advanced by the Fund's legal

counsel. More recently, HJR 83 which would create a select committee to make recommendations to the general assembly with respect to future operations of the JUA and the SRF was proposed in the legislature. These developments led to a number of meetings and as the direct result of vigorous activity by your officers and staff we are relieved and pleased to report to you that: (1) HJR 83 will be withdrawn; (2) the rule for returning the SRF will be approved with only minor changes; and (3) the rule providing for termination of the JUA has been tentatively approved pending some modification.

As the complexities of the relationships in our society have increased, we seem to have developed an increasing dependence on our staff personnel, particularly as these individuals have become progressively more knowledgeable, adept, efficient, and reliable. As this dependence has expanded, the incidence of litigation has increased, reflecting a growing dependence on legal counsel. We have

The Ohio State Medical Journal

allowed our profession to be represented more and more by surrogates to a point where we now face the possibility of delegating even purely professional and ethical decisions to lawyers and executives.

Paving the way

In any event it would appear to be time we physicians exert greater responsibility in resolving our professional problems, a clear call for wider membership participation and concern. Certainly if the ill feeling and distrust produced by legal confrontations within our profession go much further, we will have paved the way for our own self-destruction and played directly into the hands of those who would restructure the practice of medicine into an unacceptable bureaucratic monstrosity.

As changes in our society have evolved, requirements in terms of challenges to our Association have inevitably changed. Accordingly, Council has attempted during the past few years to engage in long-range planning activities quite separate and distinct from routine business of the Association in an effort to enable the OSMA to be in tune with the times.

As a preface to the planning process, a frank and sometimes brutal appraisal of the strengths and weaknesses of the OSMA was undertaken along with certain basic assumptions about the medical profession. Some of the strengths that were identified included financial solvency, a capable staff, strength of membership, the provision of many needed services, and effective legislative activity. Some of the weaknesses included occasional lack of leader credibility, unrealistic member expectations, failure to perceive certain member needs, lack of specialty representation in the House of Delegates and lack of planning and prioritization.

Major assumptions

Current life styles of our society and political realities seemed to us to require the following major assumptions for the future of our Association:

1. Legislative and Regulatory Activities of Federal and State Government. Specific areas of concern will include: (1) health resource planning; (2) health care financing; (3) quality of care; (4) health manpower supply and distribution; and (5) the

continuing attack on the professionalism of physicians. It is expected that continued governmental pressures will be closely tied to the politically sensitive issues of cost containment and catastrophic health insurance.

2. Membership and Professional Unity. As society becomes even more highly organized, all membership organizations must compete with others for members. The OSMA will face continued and possibly increased competition from the other organizations vying for physician members. In the long run, the membership problem is best approached by unifying rather than competing with other medical organizations.

3. The Economy. Inflation will

"The ability of physicians to respond to . . . concerns in a manner which is deemed satisfactory by the public will directly affect the profession's credibility and ultimately determine the future image of medicine."

continue to be a serious problem. As with other associations that are heavily dependent on dues support and consequently have a relatively fixed income base, the high rate of inflation has a depressing effect upon OSMA's ability to implement new programs and activities. Revenues from nondues sources must be investigated to limit the impact of increasing costs to the physician members. In the face of such economic realities, new programs can only be instituted at the expense of existing programs. This has important implications for the OSMA's ability to respond quickly and effectively in a dynamic environment, and will be a major concern to the Association in all future planning activities.

4. Communications Activities and the Image of the Profession. Consumer interest and involvement in the medical profession will continue to increase with emphasis on the following areas: (1) demand for more knowledge about treatment and diagnosis of illness; (2) increased media attention to new advances, especially in cancer treatment and cure; (3) physician-patient communications; (4)

rising cost of health care; (5) physician distribution shortages; (6) increased interest in capabilities of various paraprofessionals; and (7) national health insurance. It is expected that physicians will be called upon to comment, in the public forum, on these and other issues with increasing frequency with an emphasis on the socioeconomic aspects of medicine. The ability of physicians to respond to these concerns in a manner which is deemed satisfactory by the public will directly affect the profession's credibility and thus ultimately determine the future image of medicine.

Council has identified the following major operating strategies for the future. These include: (1) membership;

(2) legislation and regulation; (3) communications/public image; (4) health delivery and planning; (5) fiscal base; (6) service programs; and (7) administration.

1. Membership Development. The Association will pursue membership programs and activities designed to assure the membership levels necessary to OSMA's growth. Changes in structure of benefits and marketing techniques will be explored as ways to accomplish the necessary rate of growth in membership.

2. Legislation and Regulations/State and Federal. Overall, OSMA will continue its assertive posture with relation to health quality and delivery issues. An emphasis on problems associated with state level legislation and regulation will continue.

3. Government Relations and Health Planning (third parties directly impacting on daily practice). As health delivery patterns develop, OSMA will take a protective but assertive approach and focus primarily on preserving quality care with regard to the implementation of legislatively mandated and other programs.

4. Communications and Image.

OSMA will continue to build its identity with the public as a major, credible source of information and by developing policy positions on health issues. Specific activities aimed at the public through the media will continue, with more attention to information which meets the needs expressed in the major operating assumptions.

5. Individual Member Service

Programs. The OSMA will continue offering specialized member service programs such as insurance, leasing, supplies, and continuing medical education.

6. Fiscal Base. To assure the current and future financial soundness of the Association, revenues from nondues sources have been and will be sought. This will include increasing revenue from currently ongoing activities, developing new revenue-producing activities that are consistent with OSMA's basic objectives.

7. Administrative. The OSMA will maintain an organizational structure that can effectively meet the goals and requirements of the Association (members). Revision of the present

structure will occur when changing circumstances require it and insofar as available resources will permit.

For the first time in several years it is possible to report some good news on the FTC front. Future appropriations for this bureaucracy have been sharply curtailed pending a definition of limitation of the FTC's authority. Industry-wide rulings of the FTC could be killed by majority votes of the House and Senate. This is the first time Congress has taken such action against an independent regulatory agency.

I cannot conclude without mentioning with pride OSMA's membership statistics for 1979. Such a reference allows me to accentuate the positive. I am pleased to report that at a time when the AMA is experiencing a membership crisis the OSMA has broken the 12,000 barrier — the largest membership total in our history. It is also significant to note in Dr. Barr's report that Ohio's dues are the lowest of the most populous states which include California, New York, Pennsylvania, Illinois, Texas, and Florida. Considering the many services provided, OSMA membership is a bargain unparalleled in today's economy. **OSMA**

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TOLEDO: R. E. Stallter, Representative, 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551 (419) 874-8080

AMA Alternates

For Alternate Delegates to the American Medical Association for a term of two years beginning January 1, 1981 and ending December 31, 1982, the Nominating Committee placed in nomination the names of Drs. John H. Boyles, Jr., Dayton; Alford C. Diller, Van Wert; Stewart B. Dunsker, Cincinnati; B. Leslie Huffman, Jr., Maumee; Frederick T. Suppes, Cleveland; and Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Diller, Dunsker, Huffman and Thomas were declared elected.

For Alternate Delegate to the American Medical Association to fill a vacancy (created by the election of Dr. Fulton to AMA Delegate) immediately and to serve a one-year term beginning January 1, 1981 and ending December 31, 1981, the following were nominated from the floor: Drs. John H. Boyles, Jr., Dayton; and Thomas W. Morgan, Gallipolis. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Morgan was declared elected.

COMMITTEE ON PRESIDENT'S ADDRESS

Dr. Morgan then called for the report of the Reference Committee on President's Address, which was presented by Dr. John H. Budd, Cuyahoga County, Chairman of the Committee. The report read as follows:

President Tom Morgan presented one of the finest and most comprehensive reports on the activities, the goals and the achievements of the Ohio State Medical Association.

In these difficult times when organized medicine is so frequently suspected and accused of inactivity and disregard of its public responsibilities, it is important to remind our members, as well as the public, of the many positive contributions being made by the OSMA and its members in matters of personal and public health and as the advocate for the queen of the professions.

Dr. Morgan pointed out the multiple and varied sources from which these assaults originate and warned that self-inflicted intraprofessional disunity compounds our problems and hinders effective response.

He described the legislative challenge presented by some 200 health-related bills in our state legislature, plus many in the nation's Congress, as well as the harassment imposed by regulatory agencies. They necessitated intensive and virtually continuous activity by our legislative committee and staff.

Dr. Morgan called attention to the rapidly changing society, and the deterioration in moral climate at all levels — individual, family, national and international. These rapid changes increase the difficulty in carrying out effective planning beyond crisis response.

Despite these obstacles our successes have been conspicuous, important and inspiring. Paramount among them are:

1. Constructive guidance and needed prudent limitation of the "instant doctor syndrome."

2. Delineation of proper application of the skills of pharmacists and prevention of unwise expansion of pharmacist authority.

3. Defeat of the bill seeking permission for optometrists to use drugs on their patients.

4. ~~Inclusion in the hospital licensing bill that admitting privileges be restricted to physicians or allied professionals under physician supervision.~~ STOPPED AN ATTEMPT IN HB 753 TO GRANT PSYCHOLOGISTS, PODIATRISTS, AND PHYSICAL THERAPISTS INDEPENDENT HOSPITAL ADMITTING PRIVILEGES WITHOUT PHYSICIAN SUPERVISION.

5. Elimination of the surcharge on professional liability insurance premiums, planned return of previous such assessments and eventual phasing out of the Joint Underwriting Authority (JUA).

6. A membership roster now exceeding 12,000, the largest in our history. The public we serve is the beneficiary of these accomplishments. Dr. Morgan pointed out that the benefits described accrue to all, though the cost is borne only by these dues-paying members.

Our continuing needs are for more involvement and participation by physicians in resolving the problems we face. We must not abdicate and leave the field to those whose efforts, regardless of sincerity, would restructure the practice of medicine, as Dr. Morgan said, into a "bureaucratic monstrosity."

Our strategies for the future, Dr. Morgan said, should include:

1. Continued growth in membership.

2. Expanded physician involvement in the legislative process.

3. Leadership by OSMA as spokesman for the profession in health planning with emphasis on preservation of quality.

4. Continued service to the membership by programs of insurance, leasing, continuing medical education, and others.

5. Maintenance of our credibility and public confidence.

6. Fiscal soundness and administrative efficiency.

It is the opinion of your Committee that the goals so clearly described are both attainable and necessary, and the successes achieved justify pride and confidence in our future. They are conclusive evidence of a leadership and stewardship discharged with efficiency in fullest measure. We recommend enthusiastic endorsement of Dr. Morgan's Address.

By official action, the House amended the Report of the Committee on President's Address by deleting the language so indicated, and by adding the language set forth in capital letters, and then approved the Report.

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. Thomas P. Price, Jr., Gallia County, reported for Resolutions Committee No. 1, of which he was Chairman. The report is as follows:

RESOLUTION NO. 3-80 Principles of Medical Ethics

The Committee considered Resolutions 1, 2 and 3 together, and recommends adoption of Resolution No. 3, in lieu of 1 and 2 and Mr. President, I so move.

RESOLUTION NO. 3-80 Principles of Medical Ethics

WHEREAS, The final and interim report of the Ad Hoc Committee on the Principles of Medical Ethics was forwarded to state medical societies, specialty societies and other component medical societies for review and comment and,

WHEREAS, The Principles of Medical Ethics should be viewed as principles rather than laws and,

WHEREAS, The present Principles of Medical Ethics have served the public and the profession well; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association urge the AMA to maintain, as nearly as possible, the current Principles of Medical Ethics.

By official action, the House voted to adopt Resolution No. 3-80.

RESOLUTION NO. 4-80 Repeal of AMA Policy Regarding Interest on Unpaid Accounts

Resolution No. 4-80, Repeal of AMA Policy Regarding Interest on Unpaid Accounts, asks that the OSMA delegation to the AMA introduce an appropriate resolution to the House of Delegates of the American Medical Association to repeal AMA ethical policy preventing the charging of interest on accounts which are unreasonably overdue.

The Committee felt that it was inconsistent to recommend the maintenance as much as possible of our current medical ethics but, at the same time, requests repeal of an ethical policy regarding interest on unpaid accounts. Therefore, the Committee recommends that Resolution No. 4-80, be NOT adopted, and I so move.

By official action, the House voted to reject Resolution No. 4-80.

RESOLUTION NO. 5-80 Continuing Medical Education in Ohio

The Committee considered Resolution No. 5-80 and after much discussion, submits the following Substitute Resolution:

SUBSTITUTE RESOLUTION NO. 5-80

WHEREAS, The process of providing evidence of 150 hours of continuing medical education and the application for a certificate of triennial registration to the Ohio State Medical Board every 3 years presents serious logistical problems; THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association continue to explore all possible avenues of making the renewal process more efficient.

Mr. President, the Committee recommends adoption of Substitute Resolution No. 5-80, and I so move.

By official action, the House voted to adopt Substitute Resolution No. 5-80.

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RESOLUTION NO. 6-80

Accreditation of CME Programs

The Committee discussed this resolution and submitted the following Amended Resolution No. 6-80:

AMENDED RESOLUTION NO. 6-80

WHEREAS, Continuing Medical Education programs should be readily available to physicians in Ohio, and WHEREAS, Accreditation of CME programs should remain within the control of the medical profession, THEREFORE BE IT

RESOLVED, That the OSMA through its delegation to the AMA urge the House of Delegates of the AMA to encourage its officers and staff to continue to work with the remaining members of the LCCME to achieve an appropriate and equitable resolution of the problems and the reestablishment of a single accrediting agency for CME, and BE IT FURTHER

RESOLVED, That the AMA be urged to continue the function of CACME until such time as an appropriate single accrediting agency for CME is established.

Mr. President, the Committee recommends adoption of Amended Substitute Resolution No. 6-80, and I so move.

By official action, the House voted to adopt Amended Resolution No. 6-80.

RESOLUTION NO. 7-80

Mandatory Continuing Medical Education

The Committee discussed Resolution No. 7-80 and recommends adoption of the following amended resolution:

AMENDED RESOLUTION NO. 7-80
Mandatory Continuing Medical Education

WHEREAS, Documentation of 150 hours of CME every 3 years is now a requirement for Ohio medical reregistration of certificate, and WHEREAS, The cost for this effort is excessive, not counting the value of the time taken from practice, and WHEREAS, There is no evidence to show that compulsory CME improves patient care or reduces exposure to professional liability claims, THEREFORE BE IT

RESOLVED, That the OSMA is opposed to compulsory continuing medical education as a requirement for reregistration of certificate and will attempt to initiate legislation at an appropriate time to abolish this requirement.

By official action, the House voted to adopt Amended Resolution No. 7-80.

RESOLUTION NO. 8-80

**Ohio State Medical Association
Responsibility for Continuing Medical
Education**

This resolution was discussed and it was felt by the Committee that other actions were being taken by the Ohio State Medical Board to accomplish the same objective.

Mr. President, I move that this resolution NOT be adopted.

By official action, the House voted to reject Resolution No. 8-80.

RESOLUTION NO. 9-80

Funding for the Ohio State Medical Board

The Committee next discussed Resolution No. 9-80 regarding funding for the Ohio State Medical Board and, after due consideration, recommended the adoption of the resolution and, Mr. President, I so move.

RESOLUTION NO. 9-80

Funding for the Ohio State Medical Board

WHEREAS, Section 4731.281 of the Ohio Revised Code requires that a physician pay a fee of fifty dollars at the time of each triennial registration and,

WHEREAS, The Ohio State Medical Board is dependent upon the Ohio General Assembly for its funding and, WHEREAS, The Ohio State Medical Board could improve its effectiveness if it had additional funds for increased staff; THEREFORE BE IT

RESOLVED, That the OSMA encourage the General Assembly to allocate adequate funds for optimal operation of the Ohio State Medical Board.

By official action, the House voted to adopt Resolution No. 9-80.

RESOLUTION NO. 11-80

Determination of Death

The Committee considered Resolution No. 10, Definition of Death, and Resolution No. 11, Determination of Death, together, and felt that Resolution No. 11 embodied the principles of Resolution No. 10. The Committee recommends that Resolution No. 11-80 be adopted in lieu thereof, and Mr. President, I so move.

RESOLUTION NO. 11-80

Determination of Death

WHEREAS, The State of Ohio does not have legal criteria for the determination of death and, as such, in certain instances, the patient, society and physician may be denied certain benefits and protection, be it RESOLVED, That the OSMA actively support legislation in the form of the Model Bill of the AMA in reference to legal determination of death.

By official action, the House voted to adopt Resolution No. 11-80, with the understanding that the word "entire," in line 3, Section 1, of the Model Bill, be deleted if legislation in the form of the Model Bill were introduced in Ohio.

RESOLUTION NO. 12-80

Mandatory Living Will Proposals

The Committee, after much discussion, felt that this resolution should NOT be adopted and Mr. President, I so move.

By official action, the House voted to reject Resolution No. 12-80.

RESOLUTION NO. 13-80

Informed Consent Concerning Abortion

The Committee discussed this resolution in detail and it was the decision of the Committee that the existing guidelines embodied in Resolution 13-73 are still current and appropriate.

Mr. President, I move that Resolution No. 13-80 be NOT adopted.

By official action, the House voted to reject Resolution No. 13-80.

RESOLUTION NO. 14-80

**Commendation to 11th District Councilor
Baird Pfahl, M.D.**

The Committee discussed Resolution No. 14-80, which commends 11th District Councilor, Baird Pfahl, M.D. The Committee recommends the adoption of the resolution and, Mr. President I so move.

Mr. President, the Committee recommends that the Council devise an appropriate method of assigning and considering resolutions of commendation.

RESOLUTION NO. 14-80

**Commendation to 11th District Councilor
Baird Pfahl, M.D.**

WHEREAS, Baird Pfahl, M.D., Councilor of 11th District was recently duly honored by his community for his unselfish, exemplary, and outstanding contribution as a leading proponent of the Rotary Foundation, chairman of the local Foundation, active on District level, serving Rotary as Governor's aide, and receiving the coveted recognition as a Paul Harris Fellow, THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association extend a note of commendation to Doctor Pfahl for his outstanding and exemplary service to his community.

By official action, the House voted to adopt Resolution No. 14-80.

RESOLUTION NO. 15-80

**Promoting and Strengthening Freedom for
All: The Americanism Foundation**

The Committee wishes to commend Dr. Nino Camardese for his patriotism and hard work. We feel that the Ohio State Medical Association should encourage all physicians to take a leadership role in civic activities as well as in programs for the education of our youth in the importance of freedom and individual liberty. However, the Committee felt that this resolution should NOT be adopted and Mr. President, I so move.

By official action, the House voted to reject Resolution No. 15-80.

RESOLUTION NO. 16-80

C. T. Scanning

After much discussion, the Committee offers the following Amended Resolution 16-80 regarding C. T. Scanning:

AMENDED RESOLUTION NO. 16-80

C. T. Scanning

WHEREAS, The C. T. Scan has become the most effective and efficient method of diagnosis in many common medical disorders, and

WHEREAS, Improved diagnosis leads to improved care and shorter hospitalization, and

WHEREAS, Economic studies show that C. T. Scanning equipment is cost effective, and

WHEREAS, The cost of a scan is often less than one day in the hospital, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association recommends that C. T. Scanning equipment should be readily available for patients in community hospitals, and BE IT FURTHER

RESOLVED, That efforts by Health Systems Agencies to block the acquisition of scanning equipment by hospitals are deemed to be detrimental to the quality and cost effectiveness of health care, and BE IT FURTHER

RESOLVED, THAT A COPY OF THIS RESOLUTION BE SENT TO EACH HSA IN OHIO, THE SHIPDA, THE SCHICTA, AND THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH AND, BE IT FURTHER RESOLVED, THAT THE OSMA DELEGATION TO THE AMA INTRODUCE AND SUPPORT A SIMILAR RESOLUTION INTO THE HOUSE OF DELEGATES OF THE AMA TO RESCIND THE CURRENT RESTRICTIONS LIMITING THE ACQUISITION OF C. T. SCANNING EQUIPMENT.

The Committee recommends the adoption of this Amended Resolution No. 16-80 and I so move.

By official action, the House *voted to amend and to adopt Amended Resolution No. 16-80. The amendments are indicated in capital letters.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. A. Robert Davies, Miami County, reported for Resolutions Committee No. 2, of which he was Chairman. The report is as follows:

RESOLUTION NO. 19-80 Implementation of Report G of the AMA

The Committee placed Resolution 19-80 on the Consent Calendar and recommended adoption. The resolution reads as follows:

WHEREAS, The House of Delegates of the AMA at its Interim Meeting in 1979 has approved Section I of Report G of the Board of Trustees of the AMA, and WHEREAS, The subject of Report G of the Board of Trustees was the Final Report of the Ad Hoc Committee on Foreign Medical Graduate Affairs, and WHEREAS, In Section I the following provisions were recommended to the AMA:

- 1.1) For the next three years, actively seek qualified foreign medical graduates for nomination or appointment to the councils of the AMA

- 1.2) Develop a special effort to recruit FMGs to AMA membership
- 1.3) Encourage state medical societies to make an effort to include qualified foreign-trained physicians among their nominees for medical licensing boards
- 1.4) Consider appointing a qualified FMG as one of its representatives to the ECFMG Board of Trustees

- 1.5) Encourage state, county, and specialty medical organizations to make a special effort to encourage membership and participation by FMGs, THEREFORE BE IT

RESOLVED, That the House of Delegates of OSMA approve and encourage the implementation of Section I of Report G of the Board of Trustees of the AMA as approved by the House of Delegates of the AMA at the 1979 Interim Meeting.

By consent the House adopted *Resolution No. 19-80.*

RESOLUTION NO. 20-80 Public Relations

While the Committee agrees with the intent of the resolution, that is, to promote accurate dissemination of medical information locally, it was pointed out by several members of the Committee that implementation of this resolution would not be practical in many localities of the state. It was further considered that in certain counties the medical society would be the appropriate organization to speak with a unified voice for medicine.

Accordingly Resolutions Committee No. 2 recommends that Resolution 20-80 be NOT adopted and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 20-80.*

RESOLUTION NO. 21-80 Facilitating and Encouraging Communications

The Committee heard extensive testimony regarding the need to facilitate communication among members of the Ohio State Medical Association and the Ohio State Medical Association staff and officers. The costs of a WATS Line were described. Other suggestions in addition to the WATS Line were heard including an outgoing WATS Line and a recorder-answering device for after-hours use. Resolutions Committee No. 2 recommends that Resolution 21-80 be referred to the OSMA Council for study and for decision regarding economical implementation of these procedures for improving communications and, Mr. President, I so move.

RESOLUTION NO. 21-80 Facilitating and Encouraging Communications

WHEREAS, The OSMA Survey of September, 1979 showed that of 4,184 respondents 912 had "contacted OSMA during the past 12 months for information/assistance," and WHEREAS, Of 3,276 respondents to the OSMA Survey 1,030 rated OSMA Staff contacts "effective or very effective" in "keeping you abreast of OSMA activities" and;

WHEREAS, A WATS Line Telephone System would:

- 1) Facilitate communications.
- 2) Encourage members to contact OSMA Staff more readily.
- 3) Be a tangible, very meaningful service that the Ohio State Medical Association would offer its members — as some other State Medical Associations do; and

WHEREAS, In today's times there is great need to promote the above THEREFORE BE IT RESOLVED, That members of the Ohio State Medical Association House of Delegates consider favorably the installation of a WATS Line Telephone Service by the Ohio State Medical Association.

By official action, the House *voted to refer Resolution No. 21-80 to the OSMA Council for study and disposition prior to the 1981 House of Delegates meeting.*

RESOLUTION NO. 22-80 Letters to the Editor of the Ohio State Medical Journal

We invite the attention of the House of Delegates to the fact that an Ad Hoc Committee on *Letters to the Editor and Editorial Policy* made specific recommendations to the Council of the Ohio State Medical Association in November, 1979 concerning editorial policy. The role of the editor of the Ohio State Medical Journal and the role of the Editorial Committee of the Council of the Ohio State Medical Association regarding the publication of letters to the editor were defined. This recommendation was accepted by the Council of the Ohio State Medical Association.

Resolutions Committee No. 2 believes that this policy has functioned satisfactorily to date and we therefore conclude that no change in that policy is necessary at this time. Considering the fact that the present policy was adopted subsequent to the incident which precipitated introduction of Resolution 22-80, it is the judgment of the Committee that the potential for abuse in editorial policy has been eliminated. Resolutions Committee No. 2 therefore recommends that Resolution No. 22-80 be NOT adopted and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 22-80.*

RESOLUTION NO. 23-80 Proposed Amendment to the Bylaws to Define Valid Ballots in Elections

The Committee heard extensive testimony regarding "single shot" voting. It is the judgment of the Committee that the voting process should not be abused and there is evidence of intent to abuse this process. We heard however no compelling evidence which indicated that the results of "single shot" or "multiple shot" voting has materially affected the *outcome* of AMA Delegate elections.

This issue occasioned heated debate in both open and closed sessions regarding a member's right to express a vote or abstain from voting. By extremely close vote the Committee recommends that Resolution 23-80 be NOT adopted and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 23-80.*

RESOLUTION NO. 24-80 **Establishment of Councilor Districts**

The Committee placed Resolution No. 24-80 on the Consent Calendar and recommended adoption. The resolution reads as follows:

RESOLVED, That Chapter 4, Section 6, of the Bylaws of the Association be amended to provide as follows:

"The House of Delegates shall establish councilor districts. The districts shall comprise one or more contiguous counties. A district society may be organized in any of the councilor districts to meet at such time or times as such society may fix."

By consent, the House *adopted Resolution No. 24-80.*

RESOLUTION NO. 25-80 **Representation of Specialty Societies in OSMA Delegations**

RESOLUTION NO. 26-80 **Medical Specialty Representation in OSMA House of Delegates**

RESOLUTION NO. 27-80 **Specialty Society Representation in OSMA**

The Committee heard extensive testimony concerning Resolutions 25, 26, and 27-80. After much discussion in Committee it was decided that Resolution 25-80 directing the Council to develop constitutional changes for specialty society representation was fulfilled by Resolution 26-80 as submitted by the Council. It is the Committee's judgment that Resolution 25-80 is therefore unnecessary and that it should be rejected.

In the discussion of Resolution 27-80 the Committee and its author considered that representation by the over 60 specialty groups recognized by the American Medical Association for representation would add an excessive number of delegates and alternates to this annual meeting. The Committee recommends therefore that Resolution 27-80 also be rejected.

The Committee considered as well, extensive testimony regarding Resolution 26-80. The testimony regarding this resolution was in the judgment of the Committee approximately evenly divided. Although this resolution presented mechanisms for constitutional revision permitting representation of medical specialty societies, the Committee considered that these mechanisms were not clearly defined. Furthermore, the Committee could not clearly accept the concept of specialty representation in this House of Delegates. It was recommended that this resolution also be rejected.

The Resolutions Committee No. 2 therefore, Mr. President, recommends that Resolution 25-80 be *not* adopted and I so move.

Resolutions Committee No. 2 recommends that Resolution 27-80 be *not* adopted and I so move.

Resolutions Committee No. 2 recommends that Resolution 26-80 be *not* adopted and Mr. President, I so move.

By official action, the House *voted to reject Resolutions 25-80, 26-80 and 27-80.*

RESOLUTION NO. 28-80 **Semiannual Meetings of OSMA House of Delegates**

RESOLUTION NO. 29-80 **Interim Sessions of the OSMA House of Delegates**

Resolutions Committee No. 2 heard testimony from several OSMA Delegates to the American Medical Association who expressed a need for input and communication from the Ohio State Medical Association House of Delegates prior to the AMA interim meetings, as well as the AMA annual meetings. The Resolutions Committee, however, recommends that Resolutions 28-80 and 29-80 be not adopted for the following reasons:

Resolution 3-78 established meetings in the fall of each year for county medical society presidents and other invited representatives with the OSMA Delegates to the American Medical Association. Following this 3-year trial period which terminates with the fall, 1980 meeting, the efficacy of these special meetings is to be reported to the House of Delegates at the 1981 annual session of the Ohio State Medical Association.

Resolutions Committee No. 2 recommends that until assessment of the efficacy of these special meetings is heard by the House of Delegates that formal semiannual meetings or interim meetings of the House of Delegates not be planned.

In addition, the Constitution of the OSMA provides in Article V, Section 3 for special meetings at anytime upon the call of an officer and 2/3 of the Council or upon the call of at least 23 component societies.

Resolutions Committee No. 2 recommends, therefore, that Resolution 28-80 be *NOT* adopted and Mr. President, I so move.

Resolutions Committee No. 2 recommends that Resolution 29-80 be *NOT* adopted and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 28-80 and to refer Resolution No. 29-80 to the OSMA Council for study and report back to the 1981 session of the House of Delegates.*

Resolution No. 29-80 reads as follows:
WHEREAS, The pace of medical progress, as well as the volatile political atmosphere has been greatly accelerated in the past ten years; and
WHEREAS, The American Medical Association has recognized this fact and now holds an interim session of its House of Delegates on an annual basis . . . a meeting which has become increasingly important . . . so much so that business conducted at this interim session is of the same importance and magnitude as that conducted at the annual session; and

WHEREAS, Many states have recognized the advantage of having a session of their House of Delegates within sixty days of the interim session of the House of Delegates of the AMA, thus giving them the opportunity of introducing current and/or timely resolutions; and

WHEREAS, Those states not having such sessions find themselves bound by instructions and/or directives which may be outdated;

RESOLVED, That the House of Delegates of the OSMA meet in interim policy-making session not less than thirty nor more than sixty days prior to the interim session of the House of Delegates of the AMA; and BE IT FURTHER

RESOLVED, That such meeting be held in Columbus, Ohio with a Friday P.M. commencement and an adjournment no later than the Sunday P.M. immediately following the commencement of said session.

RESOLUTION NO. 30-80 **Mothers Day/Annual Meeting**

The Resolutions Committee heard testimony regarding this resolution which has to do with the conflict between annual meetings of the House of Delegates and Mother's Day. The Committee is in accord with the sense of this resolution but offers substitute Resolution 30-80 in its stead in order to address minor inaccuracies and pragmatic concerns:

SUBSTITUTE RESOLUTION 30-80 **Mother's Day/Annual Meeting**

WHEREAS, The year of 1980 has been declared the Year of The Family and
WHEREAS, Mothers are the cornerstones of the family unit and are of paramount importance in family stability, particularly physicians' families and
WHEREAS, Previous Ohio State Medical Association meetings have commonly conflicted with the particular day designated to annually honor mothers,
THEREFORE BE IT

RESOLVED, That the OSMA Council and staff make every effort to establish future annual meetings of the Association so as to avoid temporal conflict with Mother's Day.

Mr. President, I move *adoption* of Substitute Resolution No. 30-80.

By official action, the House *voted to adopt Substitute Resolution No. 30-80.*

RESOLUTION NO. 31-80 **Annual Meetings of the House of Delegates of OSMA**

RESOLUTION NO. 32-80 **Annual Meeting Timetable**

Much discussion was heard during open testimony which indicated a sincere interest in streamlining the annual meetings of the Ohio State Medical Association House of Delegates. The Committee heard testimony extolling the advantages of a Friday to Sunday meeting, as well as testimony favoring a Sunday through Tuesday meeting. Testimony from the Committee on Scientific Work expressed a number of problems that would obtain in scheduling weekend convention sites. Testimony regarding the potential loss of attendance related to separating Continuing Medical Education activities from the annual meeting was also heard.

It is the judgment of the Resolutions Committee that these two resolutions should be referred to the Council of the Ohio State Medical Association for study and that a recommendation regarding restructuring of the annual meeting be reported back to the House of Delegates at the 1981 session.

Resolutions Committee No. 2 therefore recommends that Resolution 31-80 be

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Minutes of the Second Session (Continued)
referred to OSMA Council and Mr. President, I so move.

Resolutions Committee No. 2 recommends that 32-80 be referred to Council and Mr. President, I so move.

By official action, the House *voted to refer Resolution No. 31-80 and Resolution No. 32-80 to the OSMA Council.*

RESOLUTION NO. 33-80
Proposed Amendment to the Bylaws to Change Titles of the Standing Committees

The Committee placed Resolution No. 33-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The titles of the Standing Committees of the Ohio State Medical Association should reflect the purposes and functions of the Committee;
THEREFORE BE IT

RESOLVED, That Chapter 9, Section 1, of the Bylaws of the Ohio State Medical Association be amended to read as follows:

1. Committee on Communications, 2. Committee on Program, 3. Committee on Education, 4. Committee on Judicial and Professional Relations, 5. Committee on Membership, and 6. ART AND CULTURE.

By official action, the House *voted to amend Resolution No. 33-80 as set forth in capital letters, and then adopted the Resolution as amended.*

RESOLUTION NO. 34-80
VOTING FOR AMA DELEGATES AND ALTERNATE DELEGATES

The Committee placed Resolution No. 34-80 on the Consent Calendar and recommended that it be *NOT* adopted.

By consent, the House *rejected Resolution No. 34-80.*

RESOLUTION NO. 35-80
Full Voting Privileges for Medical Students and Residents

The Committee placed Resolution No. 35-80 on the Consent Calendar and recommended that it be *NOT* adopted.

By consent, the House *rejected Resolution No. 35-80.*

RESOLUTION NO. 36-80
Election of Officers

The Committee placed Resolution No. 36-80 on the Consent Calendar and recommended that it be *NOT* adopted.

By consent the House *rejected Resolution No. 36-80.*

RESOLUTION NO. 37-80
Participation in Organized Medicine

The Committee placed Resolution No. 37-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The present system of medical care is being assaulted from many and diverse directions, and
WHEREAS, We in the system need the strongest voice possible to preserve the system from destructive assault, and

WHEREAS, Physicians are well-educated, hard-working, individualistic persons who realize that none of us can work effectively alone, nor be heard effectively alone, and

WHEREAS, Physicians vigorously support the democratic principles of free enterprise and duly elected representation, maintaining the elective options of whom to support and by way of whichever organization appears appropriate, THEREFORE

BE IT RESOLVED, That we preserve the present federation system of County Society, State Association and the American Medical Association, maintaining direct representation from local grass roots to the national forum, and

BE IT FURTHER RESOLVED, That our elected leaders in these organizations act in ways not only to inspire more participation by their members, but also to encourage nonmembers to be proud to join together in each level of representation, and

BE IT FURTHER RESOLVED, That each of us as individual members of these organizations undertake a more positive role in encouraging our nonmember peers to join us in the collective effort to preserve the free enterprise, privately responsible practice of medicine.

By consent, the House *adopted Resolution No. 37-80.*

RESOLUTION NO. 38-80
Single Membership for Organized Medicine

The Committee placed Resolution No. 38-80 on the Consent Calendar and recommended that it be *NOT* adopted.

By consent, the House *rejected Resolution No. 38-80.*

RESOLUTION NO. 39-80

The Committee placed Resolution No. 39-80 on the Consent Calendar and recommended that it be *NOT* adopted.

By consent, the House *rejected Resolution No. 39-80.*

RESOLUTION NO. 40-80
AMA Membership

The Committee placed Resolution No. 40-80 on the Consent Calendar and recommended its adoption.

The House acted to remove the Resolution from the Consent Calendar. The Resolution was then debated.

By official action, the House *voted to reject Resolution No. 40-80.*

RESOLUTION NO. 41-80
OSMA Dues Increase

Although the Committee is aware of the problems inherent in inflation and the need for a balanced budget, the Committee recommends that Resolution 41-80 (OSMA Dues Increase) be not adopted. The rationale for this recommendation is as follows:

The Committee heard no distinct evidence that maintenance of the current dues structure would necessitate restriction of any current programs.

It is the Committee's judgment that latitude exists for a moderate degree of "belt tightening" or economizing in our existing programs.

The Committee was able in good conscience to recommend rejection or evaluation of several current resolutions which would have increased costs, eg, "WATS Line," interim meetings, etc.

The Committee heard considerable concern expressed regarding the effect of rising organizational dues on membership.

The Committee heard testimony reflecting interest in limiting certain programs in the interest of restraining dues increases.

Resolutions Committee No. 2 recommends that Resolution 41-80, be *NOT* adopted and Mr. President, I so move.

By official action, the House *voted to adopt Resolution No. 41-80.*

The resolution reads as follows:

WHEREAS, The Dues Increase approved by the House of Delegates in 1978 was essentially to maintain the status quo in light of inflationary trends and is in line with sound fiscal policy for the Association; and

WHEREAS, OSMA services to the members and activities have increased beyond the level maintained at the time of the previous increase; and,

WHEREAS, The results of inflation will have a deleterious effect on the operating revenues of the Association; and,

WHEREAS, The Ohio State Medical Association ranks 37th in the 50 State Medical Societies with regard to the amount of dues assessed by its governing body; THEREFORE BE IT RESOLVED, That the dues of the Ohio State Medical Association be raised to \$195 beginning with the 1981 dues year.

RESOLUTION NO. 42-80
Site of Council Meetings

Resolution Committee No. 2 heard thoughtful testimony regarding the site of OSMA Council meetings for regular, as well as special purposes. Resolutions Committee No. 2 offers the following substitute.

SUBSTITUTE RESOLUTION 42-80
Site of Council Meetings

WHEREAS, Escalation of costs must be controlled if this organization is to be effective and efficient in the future, THEREFORE BE IT

RESOLVED, That all meetings of the Council of the Ohio State Medical Association be held in the State of Ohio and BE IT FURTHER

RESOLVED, That in the annual financial report presented to the House of Delegates more detail be accorded to Council expense, Mr. President, I move the adoption of Substitute Resolution 42-80.

By official action, the House *voted to amend the Resolution by deleting the first RESOLVED. Thereafter, the House voted to reject Substitute Resolution No. 42-80.*

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in a special base of prolonged therapeutic effect.

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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

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AVAILABLE: Bottles of 100, 500.

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Each blue tablet contains:

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DOSE: 1 to 5 tablets daily.

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Minutes of the Second Session (Continued)

RESOLUTION NO. 66-80

Establishment of a Liaison Committee for Communication and Interaction with the EPA and with State County Health Commissioners

The Committee placed Resolution No. 66-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The Ohio State Medical Association has gone on record as wanting to encourage more grass roots participation by Ohio State Physicians; and

WHEREAS, Members of the Ohio State Medical Association have limited facilities and time to express individual views on social, economic, political and environmental issues; and

WHEREAS, as members of the Ohio State Medical Association we bear an innate and absolute obligation to observe the status and state of being of all matters of medicine within our State and counties; and

WHEREAS, the status of our physical environment with regard to possible and probable variable degrees of air and water contamination and pollution that could well seriously affect the well-being of our people and of those who follow us; and

WHEREAS, as a matter of futuristic humanitarian concern, it is vital that we Doctors of Medicine, within the premises of our State and County Medical Societies, undertake critical surveillance of our environment, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association establish a formal and active committee within this State Association and with component County Medical Societies for the sole purpose of liaison with the EPA and State Health Department and local County Health Commissioners; and BE IT FURTHER

RESOLVED, that this OSMA Environmental Liaison Committee receive reports and/or communications from component society committees and react with the most expeditious and appropriate manner for maximum effectiveness.

By consent, the House adopted Resolution No. 66-80.

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Dr. Richard J. Nowak, Cuyahoga County, reported for Resolutions Committee No. 3, of which he was Chairman. The report is as follows:

RESOLUTION NO. 43-80

Physician Population in the United States

Resolution No. 43-80 deals with physician population in the United States

and refers to consultation with legislators. Since the OSMA has adopted an Amended Resolution No. 14-79 which deals with physician manpower needs in Ohio and the American Medical Association has provided a report on physician manpower and medical education, the Committee recommends that Resolution No. 43-80 be *NOT* adopted, and Mr. President, I so move.

By official action, the House *voted to reject* Resolution No. 43-80.

RESOLUTION NO. 44-80 Physicians' Assistants

In the opinion of the Committee, institutional employment of physicians' assistants would not assure adequate physician supervision. This could decrease the quality of patient care, and therefore the Committee recommends that this resolution be *NOT* adopted, and Mr. President, I so move.

By official action, the House *voted to reject* Resolution No. 44-80.

RESOLUTION NO. 45-80 The Physician's Role in Returning Patients to Their Jobs

The Committee placed Resolution No. 45-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Sickness and injury in America account for more than one half billion days lost from work each year (estimated by Bureau of Labor Statistics), at a cost to the country of over \$21 billion (estimated by National Safety Council); and

WHEREAS, It is in the interest of both worker and employer that sickness absence be kept at the lowest level commensurate with satisfactory convalescence and rehabilitation; and

WHEREAS, Economists agree that better productivity per hour will be an essential feature of our nation's effort to return to a stable economy; and

WHEREAS, Less absence from work would contribute importantly to AMA's Voluntary Effort to control the rising costs of medical care; and

WHEREAS, Physicians and surgeons are the prescribers of the amount of time an employee should remain away from work for the purposes of convalescence and rehabilitation; THEREFORE BE IT

RESOLVED, That physicians everywhere be encouraged to advise their patients to return to work at the earliest date compatible with health and safety.

By consent, the House *adopted* Resolution No. 45-80.

RESOLUTION NO. 46-80 The Practicing Physician's Need to Become Familiar with "Guidelines on Pregnancy and Work"

The Committee discussed Resolution 46-80 concerning guidelines on pregnancy and work. After due consideration, the Committee voted to recommend the following amended resolution:

Continued on page 440

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irritability
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AVAILABLE: Bottles 100, 500, 1000

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CONTINUING EDUCATION PROGRAMS

August

ANNUAL SCIENTIFIC ASSEMBLY: August 3-10; Sheraton-Columbus Hotel; sponsor: Ohio Academy of Family Physicians; 13 credit hours; no fee; contact: Mrs. Florence I. Landis, OAFP, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

SUMMER PROGRAM IN OPHTHALMOLOGY: August 17-20; Atwood Lake Lodge, Dellroy; sponsor: Ohio State University Department of Ophthalmology; Cosponsors: Grant Hospital, Children's Hospital, Columbus; 12 credit hours; fee: \$102, \$51 for residents; contact: Ohio State University Center for CME, A-352 Starling Loving Hall, 320 West Tenth Ave., Columbus 43210, phone: 614/422-4985.

September

14TH ANNUAL UROLOGY X-RAY SEMINAR: September 11-13; Carrousel Inn, Cincinnati; sponsor: University of Cincinnati Medical Center, Division of Urology; 18 credit hours; fee: \$200, \$150 for physicians-in-training; contact: Arthur T. Evans, M.D., University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4383.

MALIGNANT MELANOMA UPDATE: September 17; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$60, \$30 students or physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

UPDATE IN OBSTETRICS AND GYNECOLOGY: September 17; Holiday Inn, Kent; sponsor: Council of Chiefs of Obstetrics and Gynecology, Northeastern Ohio Universities College of Medicine; cosponsor: Aultman Hospital; 6 credit hours; fee: \$25; contact: Alvin Langer, M.D., Aultman Hospital, 2600 Sixth St. S.W., Canton 44710, phone: 216/438-6214.

UPDATE IN PULMONARY DISEASE: September 24-25; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$120, \$60 students or physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

7TH ANNUAL "PEDIATRICS FOR THE PRACTICING PHYSICIAN" SYMPOSIUM: September 26-27; Holiday Inn, Perrysburg; sponsor: Toledo Pediatric Society; cosponsor: Medical College of Ohio at Toledo; 12 credit hours; fee: \$125, no fee to residents; contact: James Lustig, M.D., St. Vincent Hospital and Medical Center, 2213 Cherry Street, Toledo 43608.



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Obituaries

FRANCIS W. EBERLY, M.D., Columbus; Ohio State University, 1954; age 54; died June 2; member OSMA and AMA.

DAVID E. FRANKEL, M.D., Cincinnati; University of Cincinnati College of Medicine, 1939; age 67; died December 30; member OSMA.

NATHAN G. GORDON, M.D., Akron; Boston University School of Medicine, Boston, 1936; age 70; died May 2; member OSMA and AMA.

GEORGE A. GRESSLE, M.D., Newark; University of Louisville School of Medicine, 1929; age 81; died April 28; member OSMA and AMA.

GEORGE S. HUNT, M.D., Hamilton; Tulane University School of Medicine, New Orleans, Louisiana, 1958; age 47; died May 15; member OSMA and AMA.

JOHN K. KEEFE, M.D., Maineville; Eccletic Medical College, Cincinnati, 1936; age 69; died November 22; member OSMA and AMA.

H. JERRY LAVENDER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1921; age 87; died March 19; member OSMA and AMA.

LOUIS A. LURIE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1911; age 93; died December 29; member OSMA and AMA.

J. REED McCLURE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1931; age 76; died November 3, 1978; member OSMA and AMA.

JAMES K. NEALON, M.D., Margate, Florida; Ohio State University College of Medicine, 1930; age 77; died April 26; member OSMA and AMA.

JOHN E. PETCOFF, M.D., Toledo; Loyola University Stritch School of Medicine, Chicago, Illinois, 1932; age 74; died April 19; member OSMA and AMA.

JOHN C. SCHMERGE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1946; age 59; died February 12; member OSMA and AMA.

MYRON W. THOMAS, M.D., Cape Coral, Florida; Ohio State University College of Medicine, 1932; age 76; died April 25; member OSMA and AMA.

JEFFERSON C. WOODBURY, M.D., Akron; Indiana University School of Medicine, Indianapolis, 1947; age 55; died May 10; member OSMA and AMA.



John R. Little
Fred V. Lucas, Jr.
Ronald A. Millar
James E. Montie
Patrick J. O'Hara
Emil P. Paganini
Young R. Park
Carlos A. Perez
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Vinod S. Joshi

The road to the Boston Marathon is taken one step at a time. That's the only way to handle the teasing, frustrating, sometimes painful curves that lie along its path. Yet for every athlete who challenges it, there is a reward . . . and once taken, it's a road few forget.

By Karen S. Edwards

The road to Boston

1 Step: — Ease on down the road

It's a long way from Canfield, Ohio to the Boston Marathon, but for Jack Schreiber, M.D., a Canfield family practitioner, the trip started easily enough.

"It was a rainy New Year's Day, 1975. After ten straight hours of television viewing, I had to go out for some air," he recalls.

Outside, it was too wet for a walk, so he decided to run.

"I came back in feeling so good that I ran again the next day, just to see if it would have the same effect."

It did, and before Dr. Schreiber knew it, he was on the road to Boston.

"I've never been much of an athlete," Dr. Schreiber will tell you, though he says the incentive has always been there.

"I was too short for football and basketball, and even on the college swimming team I was a third stringer and never got to compete."

So, sports have been a vicarious enjoyment for him. He enjoys them as a spectator and, he admits, as a daydreamer — the one that slugs the home run during the World Series, or the one that scores the winning touchdown in the Rose Bowl.

But when he started to run, the Boston Marathon was as much a daydream as any of the others — as distant and unreal as the fabled Emerald City in the Land of Oz.

"I wasn't considering marathon or even competitive running when I started," he says. Instead, he ran for himself — for the sheer physical pleasure he derived from pounding a mile down the road, three or four times

a week. The "good feeling" he got from running never wore off and that's what kept him going when other would-be runners drop out.

Before long, his daily runs were as habitual as the rose he always wears pinned to his jacket lapel.

"My mother put a rose in my lapel before one of my first dates with Alice (now Mrs. Jack Schreiber). I've worn one ever since." Although Dr. Schreiber is a rosarian and usually provides his own boutonniere, a patient provides him with handcrafted ribbon roses when the real thing's not in season.

2 Step: — The pace quickens

Roses are never part of the running suit, however. Soon after joining a group of friends who also run, Dr. Schreiber's one-mile "sprint" turned into a daily two-mile, then eventually, six-mile run.

"We started running around the high school track for two miles. After all, once you've done one mile for awhile, what's two? The six miles came with time, but now it's comfortable for us."

The six miles can also be comfortably done in about 45 minutes. What with the warm-ups and cool-downs, it makes for a convenient hour's worth of exercise.

For Dr. Schreiber, that hour usually begins at 5:30 a.m.

"It's a good time for me. It's easy to fit into my schedule, and I enjoy the quiet and solitude at that hour."

It's especially conducive to the type of spiritual and psychological thinking he does as he runs.

"I say my prayers every morning

during my run, and I use the rest of the time for some self-examination."

That time, he feels, has been well spent in making him more patient and tolerant — as a physician, as a person, and perhaps even as a competitor on the road to Boston.

3 Step: — Ah! competition

Dr. Schreiber's first steps into competitive running began at a "fun run" in Niles, Ohio.

During the start of that race, Dr. Schreiber confesses he felt no competitive drive. He was content to finish last — as long as he finished — and as the race progressed that's exactly where he was — the last runner in a pack of 100.

An overheard chance remark changed all that.

"An 11-year-old girl was running ahead of me," Dr. Schreiber recalls.





"Suddenly, someone shouted to her, 'Run, Susie. Don't let that old guy catch you!'"

Dr. Schreiber realized the "old guy" was himself, and pride spurred him right past her.

"The next runner in line was about 70 years old. I figured I should be able to pass him, too."

By the end of the race, Dr. Schreiber had finished 96th — not spectacular, but well enough to earn him a 4th place ribbon among the "45 and older" age group that had run the race.

"That's when the competitive bug bit me," he says.

The next race on the road to Boston took place in Cleveland, Ohio.

"It was half a marathon," Dr. Schreiber says, "and I finished it."

It was that accomplishment that began to make Boston look less like the Emerald City and more like a possibility every day. But the road to Boston is not paved with yellow brick and they don't give you ruby slippers to make the going any easier. He knew if he was going to run the Marathon, he was going to have to go to work.

"I began to run eight miles a day and sometime during the week I'd run a half-marathon."

A marathon is 26 miles, 285 yards. Dr. Schreiber, as knowledgeable in the sport's history as the sport itself, explained how the additional yardage came about. It seems during the 1897 Olympic games in London, the Marathon event ended 285 yards short of the Queen's box. With royal disregard for the runners' feet, the race was extended to end in front of the Queen, and tradition has kept the distance a part of the real Marathon.

Therefore, during training Dr. Schreiber runs anywhere between 50 and 60 miles a week — a distance he maintains for 10 to 12 weeks before a

big race. But with increased road time come increased hazards.

"I've been bitten by a dog, I've been run over by a car," Dr. Schreiber says, and while neither of them created any setbacks for him, he admits, "they did slow me down a bit."

4 Step: — Boston and Back

Then came Skylon, an obscure little marathon run between Buffalo, New York and Niagara Falls. Skylon became Dr. Schreiber's last step on the road to Boston. It was his qualifier — the key that would get him into the Emerald City. He ran it, he finished it, and in April 1978, all his daydreams culminated in the exciting reality of the Boston Marathon.

"I knew I wasn't Bill Rodgers (the winner of the last two Boston Marathons) — but I was there. I was really going to race in the granddaddy of them all!"

Bolstered by what Dr. Schreiber describes as "incredible spectator support," he ran the race — and finished it.

"The last six miles my son, Mark, jumped in and ran beside me," Dr. Schreiber recalls. "He got the same encouragement from the spectators that I had experienced the whole race. I think it was instrumental in what followed."

What followed was an idea — broached by son, Mark, the next year — that the two run the Boston Marathon together.

Dr. Schreiber, at first, expressed concern.

"Mark had recently been married, and was going to medical school in Cincinnati. I didn't know how he was

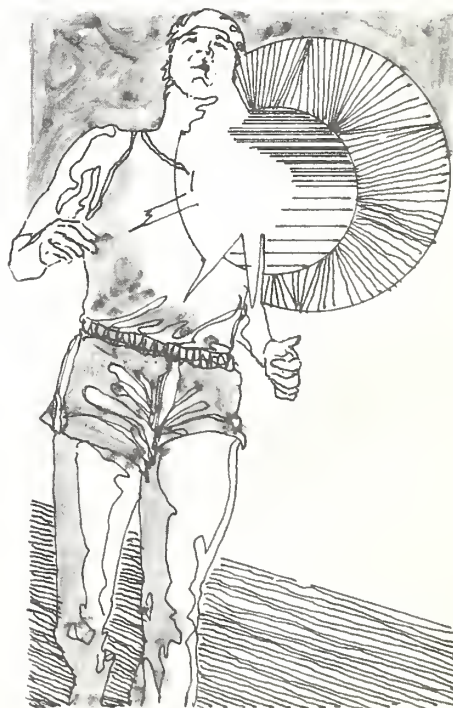
going to find the time to train."

But Mark found it. They trained separately for the event, Dr. Schreiber at his home in Canfield, and Mark in Cincinnati.

"Mark came home at Easter, and we ran together for the first time," Dr. Schreiber said. They established a pace that was good for them both, then Mark returned to Cincinnati, and they continued training separately. The next time they would run together would be in Boston.

5 Step: — Boston revisited

"There's something special about the Boston Marathon," Dr. Schreiber says. "There's such an interchange with the spectators. They stand there for long hours, screaming support, handing you drinks of water. They don't care if you're Bill Rodgers or Jack Schreiber."





The whole atmosphere is exciting."

When the 1980 Marathon began, father and son were there in the crowd of runners, some 10,000 strong, experiencing the concentration, the second wind, the runner's euphoria, the pain that is all part of the Boston Marathon.

"The human body can go 20-21 miles on the body's reserved fuel. The last four or five miles the body begins to break down its own tissue," Dr. Schreiber said, explaining in part some of the reason for the pain.

But he couldn't explain the pain in his side that crept up on him during the race.

"I never knew what caused that pain," Dr. Schreiber says, "I've never had it before or since. It just came when we were well into the race and left as mysteriously."

It was apparently one of those things that befall long-distance runners. The next one happened to Mark.

"I looked over and noticed Mark was turning pale. He said he felt dizzy. I figured he hadn't had enough water at the start of the race," Dr. Schreiber says, "so I grabbed a cup of water from one of the spectators, poured some of it over Mark then gave him the rest to drink."

The water revived him — but there was still Heartbreak Hill to run.

"It's not a particularly steep hill, but there are small hills before it and the way it comes up in the race, unless you've been pacing yourself for it you're not going to make it," Dr. Schreiber says.

The hill needs psychological preparation as well. Dr. Schreiber has learned to attack it positively.

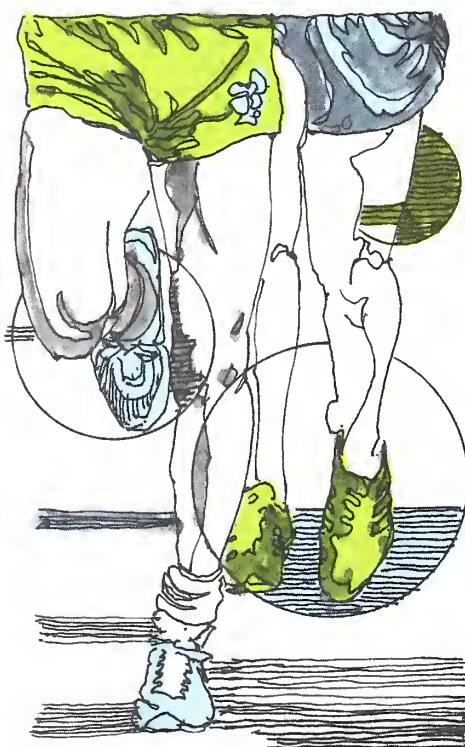
"I love hills. I eat hills for breakfast," he mutters under his breath on the way up. It's the psychological boost he needs.

This marathon a few of the spectators heard and laughed good-naturedly — but they kept right on cheering through their smiles.

"Then one of the spectators caught sight of the medical joggers' insignia on our running shirts," Dr. Schreiber said.

"Come on, doc, You can make it," the spectator yelled, and the crowd picked up the cheer. "You can do it, doc!"

"We're going to do it," the Schreibers told each other. One foot . . . then the other. Mark and his father, side by side. The finish line came into view. Bill Rodgers had long since passed it, but the spectators were still there, cheering, shouting. Mark grabbed his father's hand and lifted it triumphantly in the air as they passed the line that means the finish.



But is it?

"Mark asked me if I wanted to do it again. We're thinking about it," Dr. Schreiber says, then adds that the idea becomes more substantial each day.

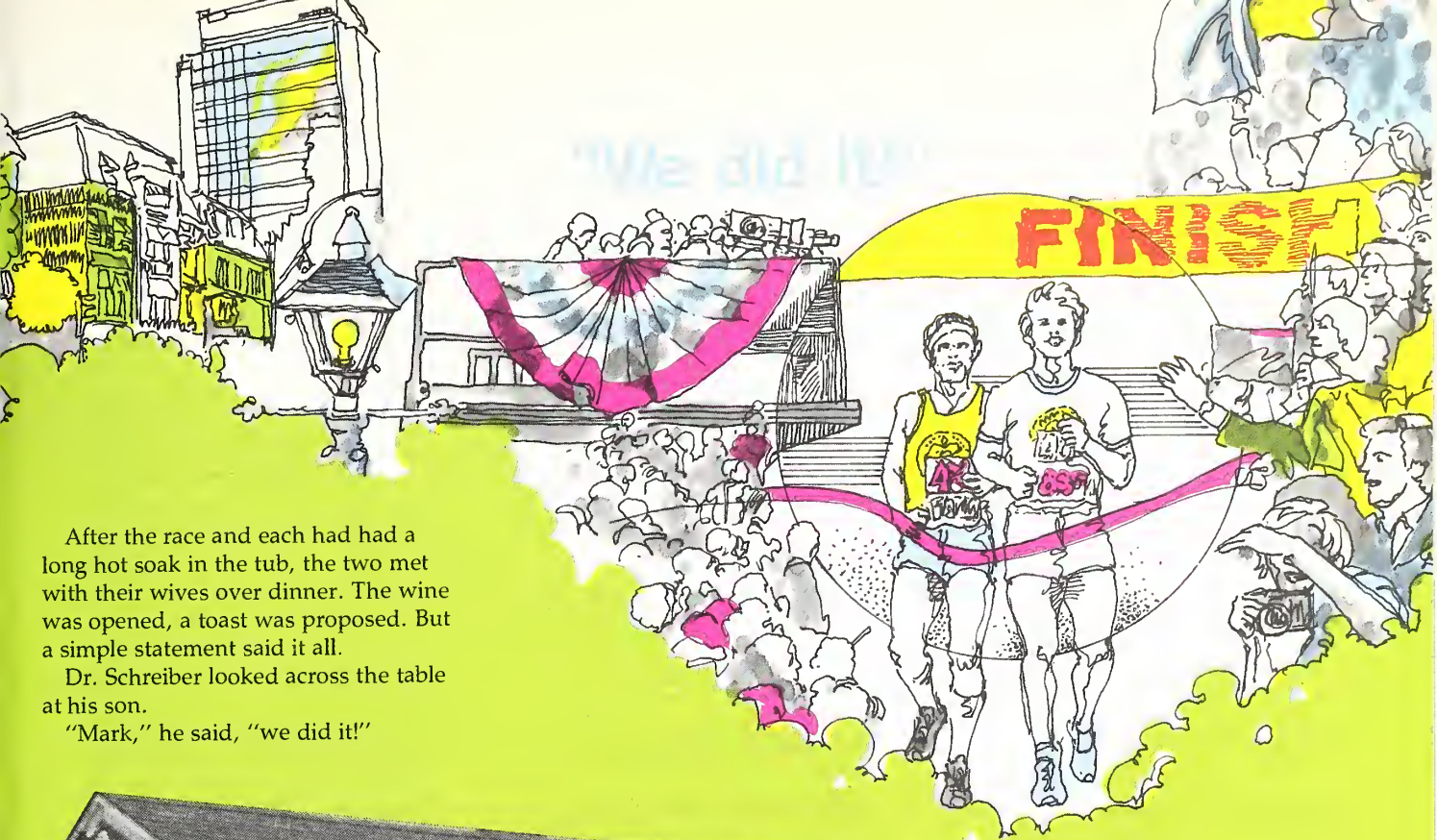
"I know now that I want to run the rest of my life. When I retire I'm going to run and audit courses at the University. I want to stay as active physically and mentally as I can."

Johnny Kelly is known as "Mr. Marathon." He won the Boston race when he was a young man and goes back every year. This year, at 72, he finished 30 seconds behind the Schreibers.

"Yeah, I can see myself doing that," Dr. Schreiber says.

But there will never be another Marathon like this year's.

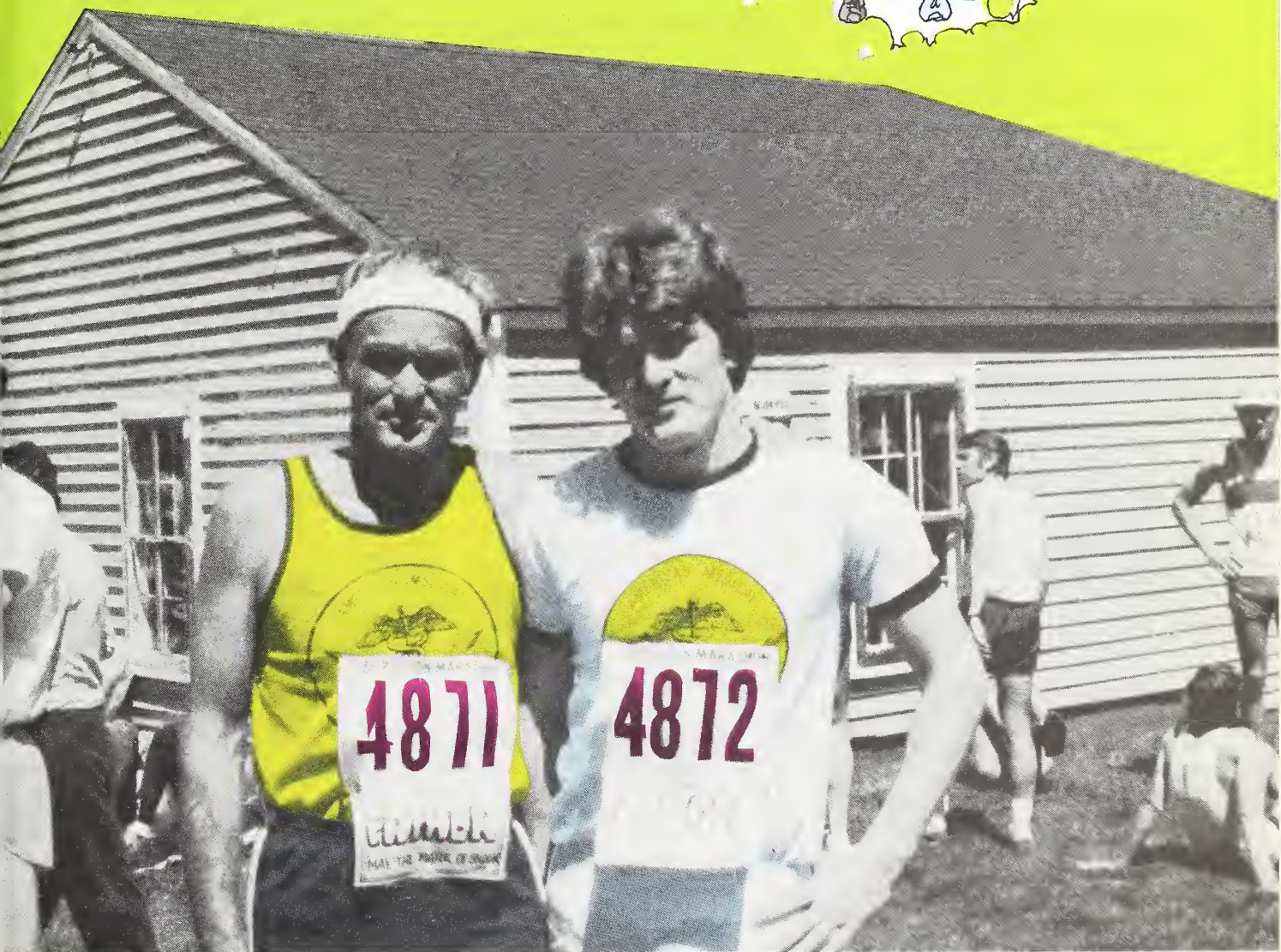
There's a lot to be said for accomplishment of self, but to a man like Jack Schreiber who is family-oriented and as emotionally charged with the pride and togetherness of a father-son relationship as any man can be, no accomplishment will ever be able to quite match what happened this year.



After the race and each had had a long hot soak in the tub, the two met with their wives over dinner. The wine was opened, a toast was proposed. But a simple statement said it all.

Dr. Schreiber looked across the table at his son.

"Mark," he said, "we did it!"



Jack Schreiber, M.D., Canfield (left) poses with his son, Mark, before the 1980 Boston Marathon.

AMENDED RESOLUTION NO. 46-80

WHEREAS, Women comprise a significant and growing portion of the American work force; and
WHEREAS, Knowledgeable industries are making marked strides at attempting to appropriately place and/or protect all employees, including the female employee and/or her fetus, from potential job risks; and
WHEREAS, PL95-555, an amendment to the Civil Rights Act, calls for disabling pregnancy-related conditions to be treated as any other disability or medical condition for all employment-related purposes, including fringe benefits; and
WHEREAS, The College of Obstetricians and Gynecologists has published a comprehensive look at the health implications of the pregnant worker in its recently published "Guidelines on Pregnancy and Work." (Obstetricians and occupational physicians collaborated in this publication to examine the work situation of the healthy pregnant woman, as well as the cases in which obstetrical, physical, chemical, or other phenomena indicate modifying a pregnant worker's job or contraindicate work altogether during pregnancy); THEREFORE BE IT
RESOLVED, That members of the Ohio State Medical Association and all practicing physicians dealing with pregnant workers be encouraged to become familiar with such publication as "Guidelines on Pregnancy and Work"* and recommend that appropriate articles be published in the OSMAGram and the Ohio State Medical Journal, and Mr. President, I so move.
**"Guidelines on Pregnancy and Work"
The American College of Obstetricians and Gynecologists
One East Wacker Drive
Chicago, Illinois 60601
By official action, the House voted to adopt
Amended Resolution No. 46-80.

SUBSTITUTE RESOLUTION NO. 47-80

WHEREAS, There has originated a request from the State of Ohio to develop legislative proposals concerning the multiplicity of private and governmental entities in Emergency Medical Services; and
WHEREAS, Involvement by all levels of the medical community in planning and implementing any legislation is of utmost importance; THEREFORE BE IT
RESOLVED, That the OSMA Committee on Emergency Medical and Disaster Medical Care and the Committee on Legislation guarantee physician involvement by actively participating and coordinating the effort of physicians at community and state levels in drafting legislative proposals in this area and in the implementation of subsequent regulations; and Mr. President, I so move.
RESOLVED, THAT THE OSMA EMPHASIZE SUPPORT OF THE CONCEPT OF LOCAL AUTONOMY AND INDICATE ITS OPPOSITION TO

ANY LEGISLATIVE PROPOSALS WHICH WOULD RESULT IN THE CREATION OF A SINGLE EMERGENCY MEDICAL SERVICES SYSTEM CONTROLLED BY THE GOVERNMENT OF THE STATE OF OHIO; AND BE IT FURTHER
RESOLVED, THAT THE OSMA TRY TO EFFECT PHYSICIAN INVOLVEMENT AND PARITY BY ACTIVELY PARTICIPATING AND COORDINATING THE EFFORT OF PHYSICIANS AT COMMUNITY AND STATE LEVELS IN DRAFTING LEGISLATIVE PROPOSALS IN THE AREA OF EMERGENCY MEDICAL SERVICES PLANNING AND IN THE IMPLEMENTATION OF SUBSEQUENT REGULATIONS. And Mr. President, I so move.

By official action, the House voted to amend Substitute Resolution No. 47-80 as indicated by deletions and by the addition of language set forth in capital letters. The House then voted to adopt the Resolution as amended.

RESOLUTION NO. 48-80
Categorization of Hospital Facilities for Emergency Medical Services

WHEREAS, The categorization of hospital facilities for emergency medical services is a controversial subject; THEREFORE BE IT
RESOLVED, That the Ohio State Medical Association House of Delegates request the Emergency Medical Services Committee of OSMA to study the issue of categorization of hospital facilities for emergency medical services and report back its findings to the House of Delegates at its next meeting.
By official action, the House voted to adopt
Resolution No. 48-80.

RESOLUTION NO. 49-80
Regionalization and Categorization of Medical Services

Regionalization and Categorization are two different entities and after consideration by the Committee, it was felt that the resolution would most likely fit regionalization. Categorization was addressed in Resolution No. 48-80. Therefore, the Committee submits the following amended resolution:

AMENDED RESOLUTION NO. 49-80
Regionalization of Medical Services

WHEREAS, The Department of Health and Human Services has mandated regionalization of medical services, beginning with Emergency Room Medical Care and Perinatal Units; and
WHEREAS, Such regionalization may result in a maldistribution of physicians leading to a reduction in the overall quality of medical care; and
WHEREAS, Such regulations may also result in the destruction of local control of health matters, as well as seriously disrupt the orderly provision of medical services to a community; THEREFORE BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association oppose the Department of HHS's present regionalization regulations; and BE IT FURTHER

RESOLVED, That the House of Delegates of the OSMA direct its delegation to the AMA to introduce and support this resolution at the 1980 Annual Meeting of the House of Delegates of the AMA, and Mr. President, I so move.

By official action, the House voted to adopt
Amended Resolution No. 49-80.

RESOLUTION NO. 50-80
Outpatient Physicians' Service Reimbursement

The Committee placed Resolution No. 50-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The federal government (FTC) supports competition in medical practice,
BE IT RESOLVED, The Ohio State Medical Association urge the Medicaid program to support competition by reimbursing outpatient physicians' services at identical rates, whether delivered in an office, ambulatory clinic, HMO, or hospital.

By consent, the House adopted Resolution
No. 50-80.

RESOLUTION NO. 51-80
Reaffirmation of Existing Policy

The Committee placed Resolution No. 51-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Resolutions presented for consideration by the House of Delegates of the Ohio State Medical Association at times result in a recommendation by a Resolutions Committee that an existing policy be reaffirmed, and

WHEREAS, A negative vote on reaffirmation may be construed to mean that existing policy is rescinded, and

WHEREAS, Such actions often result in confusion, and delay the deliberations of the House, THEREFORE BE IT

RESOLVED, That the House of Delegates of OSMA adopt a policy allowing Resolutions Committees to submit all resolutions for reaffirmation of existing policy to the House under a separate category similar to the Consent Calendar and entitled "Reaffirmation of Existing Policy."

By consent, the House adopted Resolution
No. 51-80.

RESOLUTION NO. 52-80
Universal Claim Form

Resolution No. 52-80 which deals with the universal claim form was discussed. The Committee opposed the concept of legally requiring the acceptance of a universal claim form. Basically, testimony revealed that universal claim forms are about to be accepted voluntarily and we would encourage progress toward this

goal. Therefore, the Committee recommends that Resolution No. 52-80 be *NOT* adopted, and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 52-80.*

RESOLUTION NO. 53-80 Medical Release Form

The Committee placed Resolution No. 53-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Certain health insurers have introduced a new medical information release form and,

WHEREAS, This form would authorize the release of information regarding an individual from the date of birth of that individual to the present and for a period of 24 months following the date of authorization and,

WHEREAS, The language of this medical information form would permit virtually unlimited and unrestricted acquisition and disposition of information that is unrelated to the purpose of the release; **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association object to use of any health insurance claim form which authorizes the release of information regarding an individual from the date of birth of the individual to the present or some future period after the date of authorization.

By consent, the House *adopted Resolution No. 53-80.*

RESOLUTION NO. 54-80 Certificate of Need Legislation

The Committee placed Resolution No. 54-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Blue Cross is sponsoring legislation to place the private practitioner's office under Certificate of Need control; and

WHEREAS, The Certificate of Need legislation as introduced requires a Certificate of Need if the equipment is of a sum total of \$150,000; and

WHEREAS, This type of legislation would effectively eliminate the establishment of any private offices in the practice of Pathology, Nuclear Medicine, Diagnostic Radiology, Radiation Therapy and any other multispecialty practice; and

WHEREAS, The HMOs under Blue Cross' sponsorship are exempt from Certificate of Need legislation; therefore, be it

RESOLVED, That the Ohio State Medical Association lobby fully and effectively against any legislation placing the private practitioner's office under Certificate of Need control.

By consent, the House *adopted Resolution No. 54-80.*

RESOLUTION NO. 55-80 Prompt Payment of Insurance Claims

Resolution No. 55-80 dealing with prompt payment of insurance claims was discussed by the Committee and the Committee felt it was impractical especially because of administrative problems. It was
July 1980

felt that the patient is responsible for payment of the physician's fee and it is the patient's responsibility to work out with the third-party carrier, both public and private, payment of claims for covered services. Therefore, the Committee recommends that Resolution No. 55-80 be *NOT* adopted, and Mr. President, I so move.

By official action, the House *voted to refer Resolution No. 55-80 to the OSMA Council.*

RESOLUTION NO. 56-80 Confidentiality of Physician-Patient Communications

The Committee placed Resolution No. 56-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

RESOLVED, That Ohio physicians should, in the highest and best tradition of the profession and in accordance with the Ohio law affirming the physician-patient privilege, strictly observe and hold inviolate all communications between them and their patients except in those instances where patients expressly waive the privilege or the privilege is waived by operation of law.

By consent, the House *adopted Resolution No. 56-80.*

RESOLUTION NO. 57-80 Daily Meditation in Hospitals

Resolution No. 57-80 was thoroughly discussed by the Committee. There was agreement that voluntary daily meditation in hospitals could be beneficial to many patients. The intent of the resolution was appreciated but it was felt that the OSMA should not endorse or be involved with personal religious matters. Therefore, the Committee recommends that Resolution No. 57-80 be *NOT* adopted, and Mr. President, I so move.

The House rejected the Committee's recommendation and a Substitute Resolution No. 57-80 was thereafter introduced, as follows:

SUBSTITUTE RESOLUTION NO. 57-80 Daily Meditation in Hospitals

WHEREAS, Practically all practicing physicians acknowledge the fact that equanimity, tranquility, and peace of mind can be a meaningful and positive factor in the well-being and healing process of the individual patient; and,

WHEREAS, In Huron and Erie Counties, members of the medical profession, ministerial associations, and hospital administrators are voluntarily, and thus far unanimously attempting to foster the above for their patients by effecting a 1-2 minute daily meditation time in their hospitals which would be totally voluntary on the part of all involved; **THEREFORE BE IT**

RESOLVED, That the OSMA House of Delegates acknowledge the potential benefits of such a program by sending a copy of this resolution to the Chiefs of Medical/Osteopathic staffs of hospitals in Ohio.

By official action, the House *voted to adopt Substitute Resolution No. 57-80.*

RESOLUTION NO. 58-80 To Modify the Federal Register

Resolution No. 58-80 to modify the Federal Register was discussed by the

Committee. The testimony revealed that the Federal Register is a reporting vehicle that is reviewed by several congressional oversight committees. The OSMA and the AMA monitor the Federal Register regularly. The Committee feels that for these reasons, this resolution should *NOT* be adopted, and Mr. President, I so move.

By official action, the House *voted to reject Resolution No. 58-80.*

RESOLUTION NO. 59-80 Qualifying Expert Witnesses

The Committee discussed Resolution No. 59-80 concerning qualifying expert witnesses. After due consideration, the Committee recommends the following amended resolution:

AMENDED RESOLUTION NO. 59-80

WHEREAS, The importance of an expert witness testifying for both parties in a malpractice suit is of utmost importance; and

WHEREAS, Some expert witnesses testifying are not always truly qualified to do so; and

WHEREAS, The jury may not have the expertise to realize the validity of some testimony; **THEREFORE BE IT**

RESOLVED, That the OSMA attempt to have adopted into Ohio Law qualification that an expert witness must have basic educational and professional knowledge as a general foundation for his testimony, and in addition, have current personal experience and practical familiarity with the problems that are being considered and be actively engaged in the practice of the medical subject under discussion; and **BE IT FURTHER**
RESOLVED, That such legislation shall be introduced at a time when the OSMA Task Force on Professional Liability and/or the Council of OSMA feel it is most advantageous, and Mr. President, I so move.

By official action, the House *voted to adopt Amended Resolution No. 59-80.*

RESOLUTION NO. 60-80 Labeling Generic Substitutes

The Committee placed Resolution No. 60-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Changes in the Ohio Drug Law allowed the pharmacist to substitute generic medications for brand name types unless designated otherwise by the physician; and

WHEREAS, It is often very important for the physician to know this; and

WHEREAS, It has been noted that the pharmacist will substitute a generic drug for a brand name item but label it as the brand name; **THEREFORE BE IT**

RESOLVED, That the Ohio State Medical Association work to insist through the legislature or the Pharmacy Board to insure that if a generic medication is given, that it be labeled as such and not mislabeled with a brand name.

By consent, the House *adopted Resolution No. 60-80.*

RESOLUTION NO. 61-80

Elimination of Economic Discrimination Against Patients in Community Hospitals Concerning Compensation for In-Hospital Physician Services

Resolution No. 61-80 was thoroughly discussed and found to address problems concerning physicians in nonteaching community hospitals. The Committee recommends the following amended resolution:

AMENDED RESOLUTION NO. 61-80

WHEREAS, The implementation of the Department of Health and Human Services' regulations for reimbursement of in-hospital medical services is discriminatory and may reduce the quality of patient care; THEREFORE BE IT

RESOLVED, That the OSMA oppose the position of the Department of Health and Human Services regarding payment for house physicians in nonteaching community hospitals. Mr. President, I move the adoption of this amended resolution.

The House rejected the Committee's recommendation to adopt Amended Resolution No. 61-80. Thereafter, Substitute Resolution 61-80 was introduced, as follows:

SUBSTITUTE RESOLUTION NO. 61-80

WHEREAS, The implementation of the Department of Health and Human Services' regulations for reimbursement of services provided by house officers in nonteaching hospitals is in a very unstable state, and

WHEREAS, Such a condition may reduce the quality of patient care; THEREFORE BE IT

RESOLVED, That OSMA Council study carefully the position of the Department of Health & Human Services regarding payment for house physicians in nonteaching community hospitals, and, BE IT FURTHER

RESOLVED, That the Council report to the 1981 House of Delegates on the full particulars of the implications of this position regarding the private practice of medicine in the institutional setting.

By official action, the House adopted
Substitute Resolution No. 61-80.

RESOLUTION NO. 62-80

Equitable Risk Classifications in Medical Liability Premiums

Resolution No. 62-80 points out the serious situation that exists in regard to premium schedules for medical liability insurance. There was no data on actuarial determination available for consideration. The Committee feels that further study is important to evaluate this situation. Therefore, the Committee recommends that Resolution No. 62-80 be NOT adopted, and Mr. President, I so move.

By official action, the House voted to reject Resolution No. 62-80.

Continued on page 445

- provides effective symptomatic relief
- b.i.d. dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®

azatadine maleate, 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma; increased intraocular pressure, hyperthyroidism, cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur if vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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for relief of allergy symptoms

Rx only

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

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mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

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RESOLUTION NO. 63-80

PICO Professional Liability Insurance

Testimony was given at the hearing in regard to PICO Professional liability insurance for claims-made policy to be available to residents and physicians in their first years of practice. However, it was stated that claims-made policy is available. Furthermore, discussion at the hearing indicated that an occurrence policy with a discount is being investigated and planned for implementation. The Committee, therefore, recommends that Resolution No. 63-80 be *NOT* adopted, and Mr. President, I so move.

The House rejected the Committee's recommendation. Thereafter, Substitute Resolution No. 63-80 was introduced, as follows:

SUBSTITUTE RESOLUTION NO. 63-80

WHEREAS, PICO is an insurance company for the physicians of Ohio, and

WHEREAS, Young men and women entering the practice of medicine find the costs of medical-legal insurance prohibitive, and

WHEREAS, Claims-made policies appear less adequate for long-term protection, THEREFORE BE IT RESOLVED that the House of Delegates of OSMA encourage PICO to develop and make available to residents and physicians in their first years of practice, an occurrence policy with a discounted premium to relieve their financial burden in the early years of practice.

By official action, the House *voted to adopt Substitute Resolution No. 63-80.*

RESOLUTION NO. 65-80

Mental Health Coverage by Physician-Sponsored Health Care Plans

The Committee placed Resolution No. 65-80 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, OSMA Council on December 16-17, 1978, endorsed the following policy previously adopted by the American Medical Association House of Delegates:

"That the American Medical Association support the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other medical or physical illnesses" and

WHEREAS, Physician-sponsored health care plans enrolling thousands of Ohio citizens are either underway or being planned within the state, and

WHEREAS, There is concern that mental health coverage in some physician-sponsored health care plans in Ohio may not be equivalent in scope and duration to coverage provided for other medical or physical illnesses, THEREFORE BE IT

RESOLVED, That the OSMA House of Delegates reaffirm the policy adopted by Council on December 16-17, 1978, and BE IT FURTHER

INSTANT LEASING

1980 Olds Cutlass

LS Sedan 4-dr., V-6, full equip. 36 mo. closed end. Price includes sales tax..... **\$201³⁹**
per mo.

1980 Olds Custom Cruiser Wagon

Diesel, loaded. 36 mo. closed end. Price includes sales tax..... **\$285⁷⁶**
per mo.

1980 Olds 98 Regency Sedan

Loaded. 36 mo. closed end. Price includes sales tax..... **\$294⁶⁶**
per mo.

1980 Olds Toronado Brougham

Loaded. 36 mo. closed end. Price includes sales tax..... **\$329⁸¹**
per mo.

1980 Cutlass Cruiser Wagon

V-6, air, t. glass, auto., PS., PB., cruise control, AM radio. Closed end. 36 mo. Price includes sales tax..... **\$205⁷¹**
per mo.

1980 Delta 88 Sedan

307 V-8, fully equipped. 36 mo. closed end. Price includes sales tax. Free loaner car..... **\$223⁹⁶**
per mo.

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2.4 litre, 4-cyl. diesel. 48 mo. closed end. Price includes sales tax..... **\$474²⁷**
per mo.

1980 Mercedes-Benz 450 SEL

4.5 litre, V-8. 48 mo. closed end lease, price includes sales tax..... **\$826¹⁰**
per mo.

1980 Mercedes-Benz 450 SL

4.5 litre, fuel-injected overhead cam V-8. 48 mo. closed end lease, price includes sales tax..... **\$910⁸⁰**
per mo.

1980 Sedan DeVille

loaded, 36 mo. closed end lease, price includes sales tax..... **\$359⁴³**
per mo.

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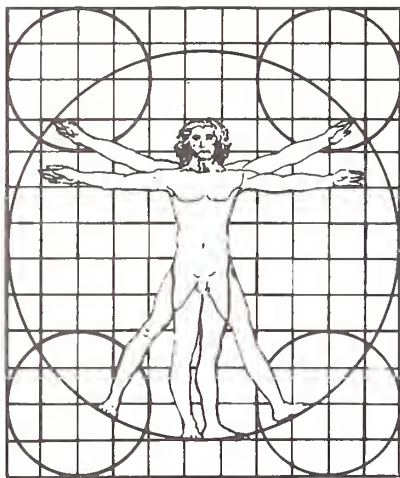
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CLINICAL & SCIENTIFIC

The Operative Management of Symptomatic Esophageal Reflux

Brian D. Lowery, M.D., Ph.D.
Patrick Vaccaro, M.D.
Eric Anderson, M.D.
Larry C. Carey, M.D.

Relaxation of the lower esophageal barrier permits gastroesophageal reflux producing symptomatic esophagitis. Operation is indicated by evidence of ulceration or stricture on esophagoscopy. Operations to mobilize the esophagus into the positive pressure zone of the abdomen and create a flap valve by plicating gastric fundus around the esophagus accomplish transmission of intraabdominal or intragastric pressure to the esophagus, and reflux is prevented. Of 71 patients who underwent operation (Nissen 43, Belsey 17, Allison 8, Hill 2, and Thal 2), seven had postoperative morbidity (10%) and one died (1.4%). Of 52 of the 71 patients responding to a questionnaire after follow-up treatment averaging 21 months, 49 were significantly improved, and 50 said they again would choose operation. There is low risk associated with current technics for treating reflux esophagitis and they provide a high degree of patient satisfaction.

SINCE ALLISON REPORTED in 1951 that heartburn, gastric flatulence, and postural regurgitation were due to peptic esophagitis caused by gastroesophageal reflux, great improvements have been made in the understanding and therapy of the associated syndromes.¹⁻⁴

Sliding hiatus hernia, so commonly diagnosed, is now known *not* to be the culprit causing gastroesophageal reflux. Rather, reflux occurs with incompetence of the "one-way valve" of the lower esophagus, with or without a hiatus hernia. If reflux is severe enough to overwhelm the normally efficient acid-clearing mechanism of the esophagus, peptic or reflux esophagitis occurs with its complications, ulceration, stricture, chronic bleeding, and rarely, perforation, or massive bleeding.

Patients whose conditions are refractory to medication and other nonoperative treatment who have undergone physiologically oriented operations (not just hiatus hernia repairs), have shown great improvement, and morbidity has been decreased. We report the experience of such patients.

Patients and Methods

From January 1975 to June 1977, 71 patients were operated on at The Ohio State University Hospitals for

symptomatic gastroesophageal reflux. There were 31 men ranging in age from 17 to 86 years (average 54 years), and 40 women ranging from 33 to 75 years (average 52 years). All had failed to respond to medical treatment. Patients with primary motility disturbances due to scleroderma, achalasia, or diffuse esophageal spasm were excluded. A detailed form was used to record preoperative symptoms, preoperative diagnostic studies, indications for surgery, type of procedure employed, and postoperative results. Special note was made of pain, regurgitation, dysphagia, or atypical symptoms such as pulmonary aspiration or angina-like symptoms. Primary indications for surgery were symptomatic esophagitis unresponsive to nonoperative therapy, or evidence of stricture formation.

Postoperative observations ranged from 3 to 33 months. Fifty-two of the 71 patients responded to a comprehensive postoperative questionnaire which covered in detail the resolution of preoperative symptoms, new postoperative symptoms, change in bowel habits, ability to eructate and vomit, weight change, and overall satisfaction with the result of surgery.

Results

Preoperative Symptoms and Signs.—The usual diversity

continued on page 445

Dr. Lowery, Columbus, Attending Surgeon, The Ohio State University Hospitals; and Assistant Professor of Surgery, The Ohio State University College of Medicine.

Dr. Vaccaro, Columbus, Chief Administrative Resident in Surgery, The Ohio State University Hospitals; and Clinical Instructor in Surgery, The Ohio State University College of Medicine.

Dr. Anderson, Columbus, Senior Resident in General Surgery, The Ohio State University Hospitals; and Clinical Instructor in Surgery, The Ohio State University College of Medicine.

Dr. Carey, Columbus, Robert M. Zollinger Professor and Chairman, Department of Surgery, The Ohio State University College of Medicine; and Medical Staff, Grant Hospital.

Submitted October 26, 1979.

of preoperative symptoms was identified. Forty-nine of the 71 patients (69%) had typical substernal or epigastric burning discomfort and heartburn; 30 patients (44%) had sour regurgitation; and 15 (21%) had dysphagia. A number had classic pyrosis, the combination of heartburn and sour acid regurgitation. Eight (11%) had chronic blood loss anemia or melena.

Preoperative Diagnostic Studies.— Fifty-four patients underwent esophagoscopy, and findings were normal in four. Forty-seven (89%) had Grade I-III esophagitis, ie, changes varying from mild erythema to severe inflammation with deep ulceration. Eight patients (14%) had a benign stricture.

Upper gastrointestinal tract barium studies performed in 58 patients were interpreted as normal in 16 (28%). Hiatus hernia was identified in 35 patients (60%). In only one instance was a Type II (paraesophageal) hernia described; all others were Type I sliding hiatus hernias (Fig. 1). Reflux significant enough to be commented upon was seen in 13 patients (22%), and either stricture or esophageal ulceration was recorded in 11 patients.

Preoperative esophageal manometric studies were not performed commonly during this period, but in the 19 patients in whom it was measured, the average lower esophageal sphincter pressure was 8-10 mm Hg. Postoperative manometry was not performed.

Operations Performed.— Operations performed in the 71 patients were the Nissen fundoplication in 43 (60%),⁵ the Mark IV repair of Belsey, et al in 17 (22%),⁶ Allison's crural repair in eight (10%),² Hill's posterior gastropexy in seven,⁷ and Thal's fundic patch procedure in eight.⁸

Perioperative Complications.— Seven patients (10%) had significant postoperative complications. Two developed small bowel obstruction requiring reoperation; two had minor wound infections; and two sustained iatrogenic injury to the spleen requiring splenectomy. A subphrenic abscess developed after splenectomy in one of these two patients and required drainage. One death occurred when a patient developed an anastomotic leak, sepsis, and massive upper gastrointestinal hemorrhage. This patient presented a complex problem. The procedure we performed had been the third attempt at operative repair of severe gastroesophageal reflux.

Later Results.— Of the 52 patients responding to our detailed postoperative questions, a number had diverse mild complaints, and some patients had more than one. Twelve reported increased diarrhea, and 19 some increase in flatulence. Seven complained of the inability to eructate postoperatively. Some degree of "heartburn" was reported by 21%, symptomatic regurgitation by 15%, and mild dysphagia by 17%. In addition, 31% had complaints of persistent incisional pain or other nonspecific abdominal pain.

Despite the variety and relatively high rate of mild postoperative symptoms, 49 of 52 patients responding (94%) were satisfied with the operative result and felt

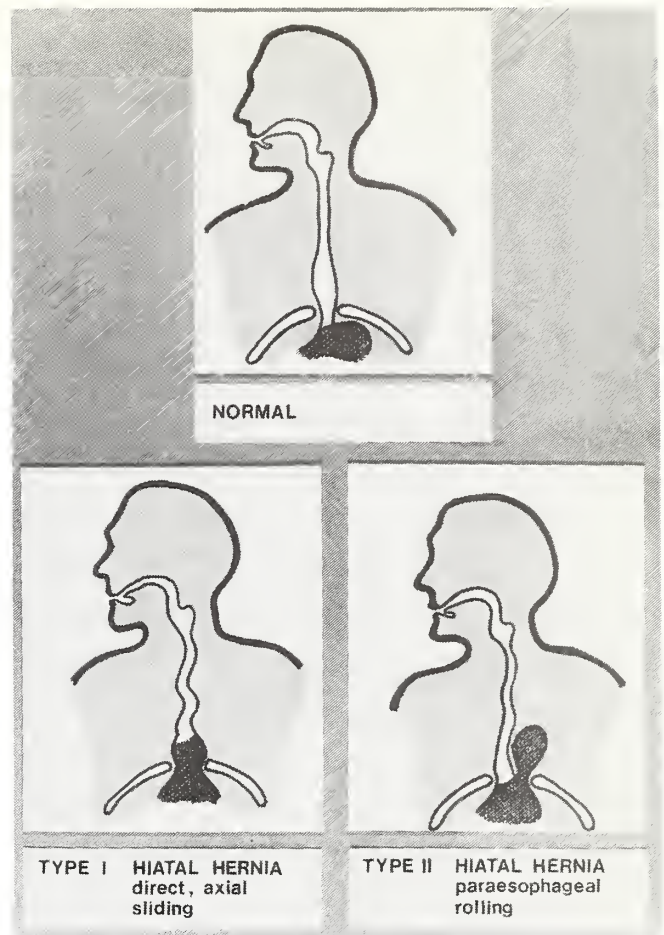


FIG. 1. Esophagogastric junction; normal contrasted to sliding hiatus hernia.

they were improved significantly over their preoperative status. Only three patients expressed dissatisfaction. We wanted to be very sure we were not minimizing the complaints and asked whether, after experiencing severe preoperative symptoms, undergoing the operation, and living with the postoperative result, they would again choose surgery. Fifty patients (96%) said they would.

Discussion

The barrier function of the esophagogastric junction is complex. Food and liquid must pass without impediment, yet gastric juice cannot be allowed to regurgitate into the esophagus to any appreciable degree. Further, belching and vomiting must be possible when comfort and illness demand. While the selective esophagogastric barrier is frequently referred to as the "lower esophageal sphincter," it is clear that no anatomic sphincter like those in the pylorus or anus is present. There is not even the blending

of voluntary muscle into the esophagus, which is present in the pharyngoesophageal barrier. The details of anatomy and physiology of this area are obscure, yet the cogent fact is that incompetence of the mechanism allows gastroesophageal reflux which in turn causes esophagitis and its complications.

An estimated 80% to 85% of patients with gastroesophageal reflux can be managed by medical therapy. Antacids, weight loss, smaller, more frequent meals, and avoidance of postures and maneuvers producing regurgitation are the most important features of medical therapy. The results of using cimetidine for gastric secretion blockade are not known, but it seems likely that this will be helpful in some patients. However, once esophagitis with ulceration is present, most patients do not respond well to nonoperative treatment.

Pyrosis, ie, heartburn with acid sour regurgitation, remains the hallmark for clinical diagnosis. Intractability is the prime indication for surgery.⁹ Dysphagia is usually a late symptom. Overt upper gastrointestinal hemorrhage is rare, but anemia from the mild chronic blood loss of esophagitis is not. Incidence of anemia in this series (11%) correlated with the severity of esophagitis and was higher than that reported in other series.

Patient Evaluation

The barium contrast examination, with specific attention to the esophagus, is the first additional examination to be obtained in the symptomatic patient. Many patients have sliding hernias as an anatomic variation without import. There is poor correlation between the presence of a sliding hiatus hernia and esophagitis; incompetence of the lower esophageal reflux barrier can occur with or without anatomic abnormality. However, the paraesophageal or rolling hernia carries a higher incidence of mechanical complications, incarceration, strangulation, perforation, and bleeding. Its radiographic diagnosis is an indication for surgical therapy.¹⁰ Fibrous stricture is the most clear-cut radiographic abnormality related to reflux esophagitis. Esophagitis itself is not well detected by the contrast study unless there is deep ulceration, which usually does not occur. Malignant disease may be suspected, or reasonably ruled out. Failure to make a conclusive diagnosis from the radiographs should not delay further studies, notably esophagoscopy.

Esophagoscopy is the keystone in confirming the diagnosis of esophagitis, determining its severity, evaluating strictures, and ruling out malignant disease. No patient should undergo surgery for gastroesophageal reflux without prior esophagoscopy. Almost all patients with disease severe enough to be refractory to medical therapy will have esophagitis, which is graded I for erythema and edema, to III for deep ulceration and early scarring. Biopsy and brush cytology are frequent adjuncts to the visualization. Actual gastroesophageal reflux cannot be reliably graded endoscopically because the presence of the foreign body esophagoscope causes relaxation of the lower

esophageal sphincter mechanism, promoting reflux into the esophagus.

Esophageal manometry can quantitate pressure changes across the lower esophageal high pressure zone and is useful for evaluating primary or acquired esophageal motility disturbance. The test also provides objective preoperative evidence of subnormal lower esophageal "sphincter" pressures and objective postoperative evidence that this pressure has been increased. We have begun to use this test more frequently.

Of the several operations that have been developed for this condition, the three most successful ones, those of Nissen, Belsey, and Hill, employ the same principles and, incidentally, were developed independently. Each emphasizes mobilizing the esophagus until a normal length is in the positive pressure zone of the abdomen and then creates a "flap valve" by wrapping or plicating redundant gastric fundus around the esophagus—hence the term, "fundoplication." These points are shown in Figure 2. The variation is in the approach, transthoracic or transabdominal, and the percentage of esophageal circumference which is wrapped. The Nissen 360-degree fundoplication can be performed through the abdomen or chest, while Hill's must be performed transabdominally, and Belsey's transthoracically. In the latter, the stomach is mobilized into the thorax and reduced back into the abdomen as a 240-degree fundoplication is completed (Fig. 3).

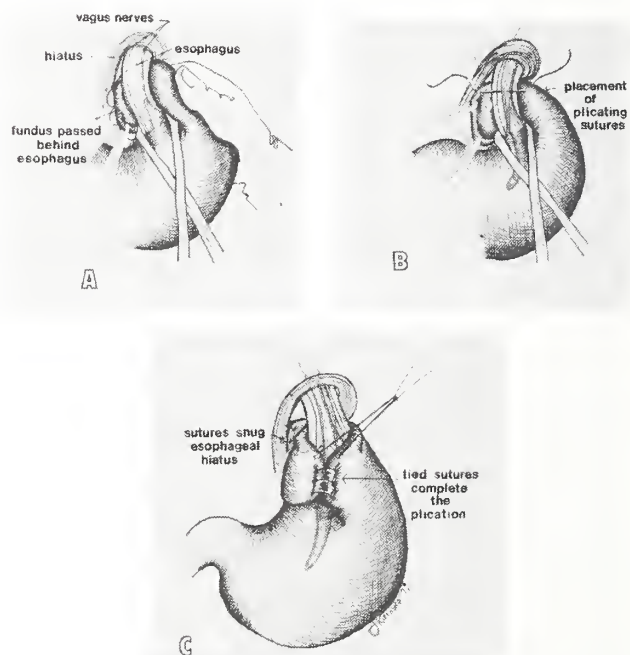


FIG. 2. The Nissen procedure, transabdominal approach.

- Several centimeters of esophagus lie without tension in the positive pressure zone of the abdomen. Redundant fundus of mobilized greater curvature is passed without tension behind the esophagus.
- Loose plication around the esophagus with sutures not entering the lumen.
- Esophageal hiatus loosely snugged over intraluminal dilator intraabdominally.

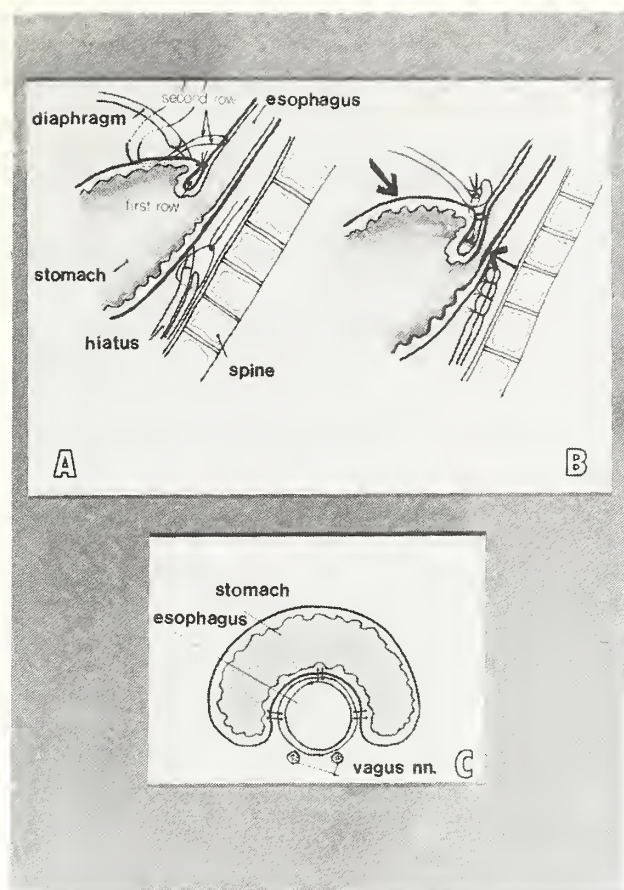


FIG. 3. Sagittal sections of Belsey Mark IV transthoracic procedure.

- A. First row of sutures between stomach and esophagus tied, second row through esophagus, stomach, and diaphragm, hiatal narrowing sutures placed.
- B. All sutures tied. Fundus plicated around two-thirds of esophageal circumference transmits intraabdominal and gastric pressure (arrows) against narrowing sutures anterior to spine.
- C. Vagus nerves preserved, although shifted in position.

While the gross appearance of these operations is different, their functional goals are identical. When intraabdominal or intragastric pressure rises, the pressure is transmitted to the "cuff" of stomach wrapped around the terminal esophagus, and reflux is prevented. When the pressures are not elevated, normal swallowing can occur (Fig. 4). The goal, then, is not to *squeeze* the esophagus with the wrapped stomach, but to create a gastric cuff around the terminal esophagus which responds to dynamic pressure changes in the stomach.

Is there a "best" operation? Several studies analyzing preoperative and early and late postoperative values of lower esophageal pressures and acid barrier function suggest that the Nissen procedure (Fig. 2) is superior.^{3,11,12} Our subjective findings corroborate these reports. Only

1 of 43 patients who had Nissen's procedure was dissatisfied.

Changes in bowel habits frequently accompany these surgical procedures, but rarely are severe enough to interfere with life style. Diarrhea has been attributed to vagal injury at the time of fundoplication.¹¹ In our experience, increased flatus and inability to eructate, components of the "gas-bloat" syndrome,¹³ were infrequent, transient, and mild. The "gas-bloat" problem is believed by some to be due to aerophagia which some patients develop preoperatively as an acid-clearing mechanism.¹⁴ This complication is less common now than after earlier procedures, when longer segments of intraabdominal esophagus were wrapped more snugly with gastric fundus.

Iatrogenic injuries to the spleen are uncommon but serious hazards of fundoplication procedures. Subphrenic abscess is reported by Polk¹⁴ as the most serious nonfatal complication of this procedure, but he noted that it did not occur in the absence of splenectomy.

The incidence of persistent or recurrent symptoms in our patients actually was higher than expected, but patient satisfaction with the result of operation was extremely high. This suggested that most postoperative problems were mild and nonprogressive and patients were able to adapt to them. We think this speaks well for the procedures, considering that all patients operated on had no success with various types of medical therapy.

The patient's ultimate measure of success is a consistent amelioration of symptoms. From this standpoint, the currently preferred technics for effective management of gastroesophageal reflux can be considered to be low-risk procedures which yield a high degree of satisfaction over the short term. They restore the competence of the esophagogastric junction as a reflux barrier, while allowing normal swallowing, belching, and vomiting.^{3,5,7,10,11} Much longer periods of follow-up will be required to assess long-term symptomatic relief and the effectiveness of these procedures in preventing the serious complications of persistent or recurrent peptic esophagitis.

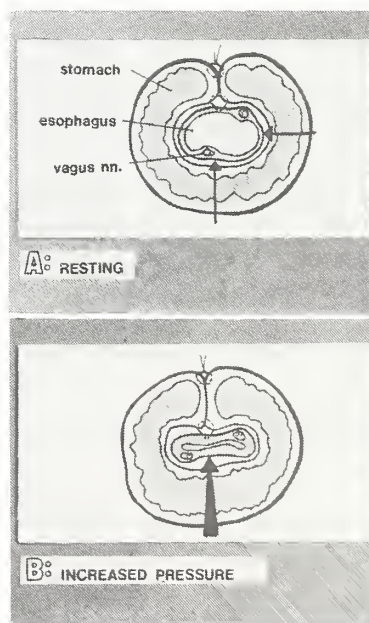


FIG. 4. Cross section, Nissen fundoplication.

- A. Mild esophageal compression at rest (arrows) presents no barrier to food.
- B. Increased intraabdominal and gastric pressure after eating, bending, lifting, etc., is transmitted to esophagus to prevent reflux.

References

1. Allison PR: Peptic ulcer of the esophagus. *Thorax* 3:20-42, 1948.
2. Allison PR: Reflux esophagitis, sliding hiatal hernia, and the anatomy of repair. *Surg Gynecol Obstet* 92:419-431, 1951.
3. Bushkin FL, Neustein CL, Parker TH, et al: Nissen fundoplication for reflux peptic esophagitis. *Ann Surg* 185:672-677, 1977.
4. Skinner DB, Belsey RHR, Hendrix TR, et al (Eds): Gastroesophageal Reflux and Hiatal Hernia, Boston, Little Brown, 1972.
5. Nissen R: Gastropexy and fundoplication in surgical treatment of hiatal hernia. *Am J Dig Dis* 6:954-961, 1961.
6. Orringer MB, Skinner DB, Belsey RHR: Long-term results of the Mark IV operation for hiatal hernia and analyses of recurrences and their treatment. *J Thorac Cardiovasc Surg* 63:25-33, 1972.
7. Hill LD: An effective operation for hiatal hernia: An eight-year appraisal. *Ann Surg* 166:681-692, 1967.
8. Thal AP: A unified approach to surgical problems of the esophagogastric junction. *Ann Surg* 168:542-550, 1968.
9. Polk HC, Zeppa R: Hiatal hernia and esophagitis: A survey of indications for operation and technic and results of fundoplication. *Ann Surg* 173:775-781, 1971.
10. Hill LD: Incarcerated paraesophageal hernia: A surgical emergency. *Am J Surg* 126:286-291, 1973.
11. DeMeester TR, Johnson LF, Kent AH: Evaluation of current operations for the prevention of gastroesophageal reflux. *Ann Surg* 180:511-525, 1974.
12. Dilling EW, Peyton MD, Cannon JP, et al: Comparison of Nissen fundoplication and Belsey Mark IV in the management of gastroesophageal reflux. *Am J Surg* 134:730-733, 1977.
13. Woodward ER, Thomas HF, McAlhany JC: Comparison of crural repair and Nissen fundoplication in the treatment of esophageal hiatus hernia with peptic esophagitis. *Ann Surg* 173:783-792, 1971.
14. Polk HC: Fundoplication for reflux esophagitis: Misadventures with the operation of choice. *Ann Surg* 183:645-652, 1976. ☆☆☆



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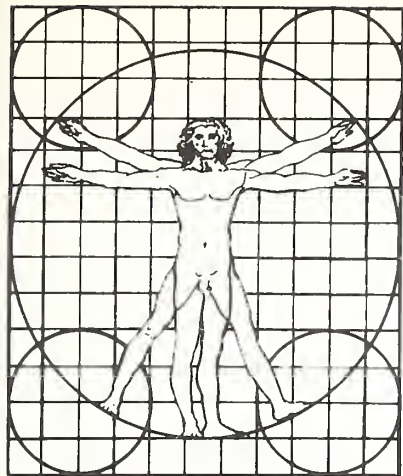
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CLINICAL & SCIENTIFIC

Why Measure Blood Pressure in Children?

Ronald J. Kallen, M.D.

All children aged 3 years or older, should have blood pressure routinely measured at yearly intervals. The inflatable portion of the sphygmomanometer cuff should have a width that approximates the distance between the axilla and antecubital fossa. The cuff should completely encircle the limb and the length should be three times greater than the width. Using a cuff of inadequate size will cause a false-high reading. There is no single blood pressure "cutoff" for the definition of hypertension in a child. Blood pressure in normal children tends to increase after 5 years of age. The best definition of hypertension in children and adolescents is a blood pressure which exceeds the 95th percentile on at least three different occasions. Most children less than 12 years of age with hypertension have a secondary cause. Renal or urinary tract disease probably accounts for at least 80% of the secondary hypertension in children. Many adolescents with hypertension also have a secondary cause but an increasing number with essential hypertension are being recognized. Predisposing factors to essential hypertension in children are overweight and a history of hypertension in the family. Essential hypertension, formerly believed to occur only in adults, now has been shown to have its onset in childhood.

THERE ARE AT LEAST two valid reasons for routinely measuring blood pressure in children. One is that most hypertension in children is secondary and an elevated blood pressure may be the first clue to an underlying, potentially serious condition. The child may be asymptomatic and yet have dangerous elevation of blood pressure, which could cause permanent injury if not controlled promptly. The underlying condition causing hypertension often is potentially correctable. If not completely correctable, detection of hypertension at least will result in therapeutic intervention, thereby preventing complications if left untreated.

A second reason for measuring blood pressure in

children is to detect those destined to develop primary (essential) hypertension in later life. Recent cross-sectional screening has defined the ranges of normal blood pressure for children of different ages.¹ Some children will have higher blood pressures than others. It is believed that children with blood pressures at, or just exceeding the upper limit of the normal range, may be destined to develop primary hypertension. Since primary hypertension often is an asymptomatic condition, despite progression of target organ damage, early detection will identify such individuals and keep them under surveillance.

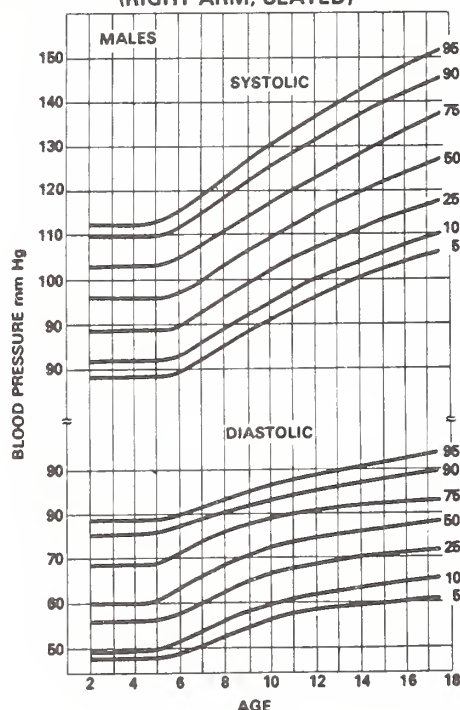
What is High Blood Pressure in Children?

The Task Force on Blood Pressure Control in Children has compiled blood pressure measurements from three different surveys of children and adolescents between 2 and 18 years of age.¹ The range of blood pressures in apparently healthy children is shown separately for males and females in the figure. It may be seen that after 5 or 6 years of age, the blood pressure of healthy children tends to increase. The graph suggests that blood pressure does not change between 2 and 5 years of age. It is not certain that this is the case; more observations are needed in the younger age group. Since children normally have a lower blood pressure than adults, the usual cutoff point for the diagnosis of borderline hypertension in adults (blood pressure greater than 140/90 mmHg) is not appropriate for children. It should be noted that a blood pressure of 120/80 represents hypertension for any child less than 7 years of age. (See figure.) Since the normal range of blood pressure varies depending on the age, there is no single cutoff level that can be used to define hypertension in children.

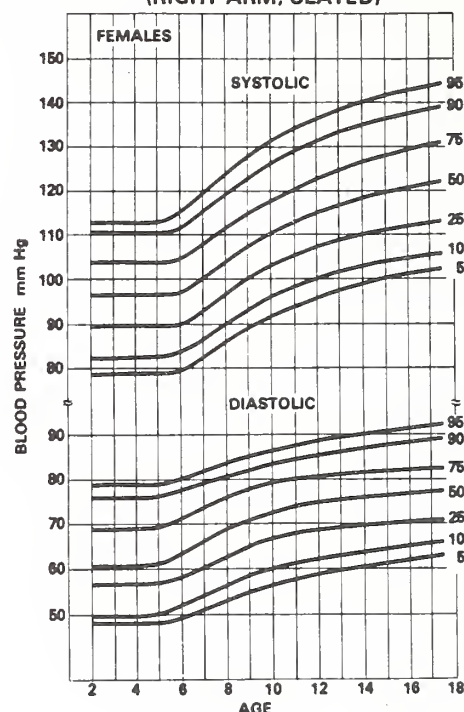
Using the Task Force charts (see figure) as a reference, hypertension is defined as a systolic or diastolic pressure exceeding the 95th percentile for that age on at least three separate occasions.¹ This 95th percentile criterion defines a different cutoff point for each age. A blood pressure at the 95th percentile means that the reading exceeds values found in 95% of children of that age,

Dr. Kallen, Cleveland, Head, Section of Pediatric Nephrology, Cleveland Clinic.
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PERCENTILES OF BLOOD PRESSURE MEASUREMENT (RIGHT ARM, SEATED)



PERCENTILES OF BLOOD PRESSURE MEASUREMENT (RIGHT ARM, SEATED)



Selected percentiles of blood pressure in males (left) and females (right) in the age range 2 to 18 years. Blood pressures were measured in the right arm, while sitting. (Reprinted by permission from *Pediatrics* 59 (5, Part 2): 797-820, 1977, Copyright 1977, American Academy of Pediatrics.)

ie, the child's blood pressure is in the upper 5% for that age. It does not mean that the child is definitely abnormal. It does mean that the probability of a normal individual having a blood pressure which exceeds the 95th percentile is only 1 in 20. It is an arbitrary cutoff and should be viewed as a guide for selecting patients for careful follow-up. Blood pressures obtained in the office should be referred to the Task Force chart in the same way that heights and weights of children are plotted on growth charts.

Of course, if the blood pressure is markedly elevated, ie, exceeds the 95th percentile by at least 20 mmHg, it may not be necessary or appropriate to wait for three successive measurements. A more intensive work-up should be initiated promptly. Only in the instance of borderline or mild blood pressure elevation should three successive measurements be done before proceeding with further work-up.

Measuring Blood Pressure in Children

Recent advances in equipment design make it possible to accurately measure blood pressure in infants and

children.² It may be difficult to obtain a reliable measurement in a struggling, crying infant or young child. However, if the child is relatively calm, a reliable auscultatory or palpatory measurement may be obtained in the usual way. The Korotkoff sounds may be difficult to hear in infants, so auscultation should be done with a pediatric-type bell or diaphragm. Because of the low volume of the Korotkoff sounds, measurement of systolic pressure can be obtained more easily in small infants by using an ultrasonic flow detector to pick up the first Korotkoff sound by means of the Doppler shift principle.³ Although the expense of such equipment militates against its practical use in the office, every hospital pediatric unit should have one.

In children 3 years of age and older, blood pressure measurement should be obtained while the child is relaxed and sitting up. The latter is important so that the measurement can be compared with the Task Force graph which is based on data obtained in the sitting position.¹ The fourth Korotkoff sound (muffling) is used as an indication of diastolic pressure, rather than disappearance of sounds.

Regardless of age, it is important that the size of the blood pressure cuff be appropriate for the size of the child. A cuff that is too small will not adequately transmit pressure through the tissues of the arm to the brachial artery until an excessive inflation pressure is achieved, giving a false-high reading. The American Heart Association recommendations as to size have been limited to the width of the cuff only. Their recommendation is that the width be 20% larger than the diameter of the arm for adults, and for children cuff width should be at least two thirds of the distance between the axilla and the antecubital fossa. However, either recommendation may result in a false-high reading.²

Recommendations as to proper cuff size vary⁴ but it is better to err on the side of being too large rather than too small. In general, the width of the cuff should be at least two thirds of the length of the upper arm and completely surround the arm, ie, the length of the cuff should equal the circumference of the arm. Using a cuff that is too large does not result in a significant underestimation of the actual arterial pressure.² Practically speaking, any cuff that comfortably fits between the axilla and the antecubital fossa and completely encircles the arm may be used. This requirement is fulfilled by a cuff length approximately three times the diameter of the arm (since circumference = diameter \times 3.14). A small degree of overlap of a cuff which more than encircles the arm does not affect the accuracy of measurement.² It should be emphasized that these recommendations apply to the size of the inflatable bladder, and not the fabric cover.

The cuff size is especially important in the obese child. Many such children are diagnosed as having hypertension when, in fact, they may be normotensive and simply have a false-high reading due to inadequate cuff size. Nevertheless, it is known that obese individuals are at higher risk of true arterial hypertension even when a cuff of appropriate size is used.⁵

It is difficult to obtain accurate measurements in younger children due to a limited range of sizes of commercially available cuffs. For example, a commercially available "newborn" cuff is totally inadequate for full-term newborns or young infants and is prone to yield false-high readings. However, it may be suitable for small premature infants. Moreover, the inflatable portion of most commercially available cuffs has a length-to-width ratio of 2. A better configuration for accuracy is a length-to-width ratio of 3 and such cuffs now are commercially available⁶ (Pedisphyg™, CAS Inc., Box 914, Upper Montclair, NJ 07043).

Causes of Hypertension in the Young

Consideration of etiology of hypertension breaks down into two major categories: primary and secondary. However, unlike hypertension in adults, wherein up to 95% are primary (essential), the vast majority of young patients have an identifiable cause. This is often the case in children less than 13 years of age. On the other hand,

an increasing number of adolescents are being referred for evaluation of possible primary hypertension.

Causes of Secondary Hypertension

The vast majority of secondary hypertension in the young is "nephropathic," ie, secondary to parenchymal renal disease. (See Table 1.) Nephropathic hypertension may account for up to 80% of all hypertension in children less than 13 years of age. Such children may be asymptomatic, with detection of hypertension as an incidental finding during the course of a routine examination. However, in most instances there are other symptoms suggesting kidney disease, such as proteinuria, hematuria, edema, failure to thrive, etc. Renovascular hypertension is less common than nephropathic hypertension but especially should be considered in children with neurofibromatosis or any infant with congestive heart failure without obvious congenital heart disease. The other conditions listed in Table 2 are less common but should be ruled out if the more common conditions are not present, especially if there are suggestive signs. For example, palpitations, tachycardia, and episodic pal-

Table 1

Renal Causes of Hypertension in Children and Adolescents

- I. Renal parenchymal disease (nephropathic hypertension)
 - A. Bilateral renal disease
 1. Glomerulonephritis
 2. Interstitial nephritis (or "pyelonephritis")
 3. Polycystic kidney disease
 4. Congenital hypoplastic disease
 5. Chronic hereditary nephritis
 6. Bilateral hydronephrosis
 - B. Unilateral renal disease
 1. Pyelonephritis
 2. Dysplasia or hypoplasia
 3. Reflux nephropathy
 4. Ask-Upmark kidney (segmental hypoplasia)
 5. Unilateral hydronephrosis
- II. Renovascular hypertension
 - A. Isolated, unilateral
 1. Main renal artery
 2. Segmental
 - B. Bilateral renal artery stenosis with hypoplasia of abdominal aorta.
 - C. Renal artery stenosis associated with neurofibromatosis.
- III. Other renal disorders
 - A. Wilms tumor
 - B. Reninoma
 - C. Post-traumatic

lor might suggest pheochromocytoma. Contrary to widespread belief, pallor rather than flushing, is a typical symptom of pheochromocytoma.

Work-up for Detection of Secondary Hypertension

Fortunately, the presence of renal disease is established readily by relatively simple and inexpensive studies, such as urinalysis, quantitative urine protein, BUN, and serum creatinine. Unless the patient has a fully developed "nephritic syndrome," with hypertension accompanied by hematuria, erythrocyte casts, edema, azotemia, and oliguria, an intravenous urogram should be done. If the child is markedly azotemic and the urogram does not give adequate visualization, renal size may be evaluated by ultrasound examination. Generally, there is no reason to obtain additional, expensive tests such as plasma renin activity, plasma and urinary aldosterone, plasma and urinary catecholamines, and corticosteroid excretion studies, unless the work-up fails to reveal a nephropathic or renal vascular basis for hypertension.

A voiding cystourethrogram always should be done if the child has had a history of recurrent, unexplained fevers as an infant and if the urogram shows disparity in renal size, blunting of calyces, renal cortical scarring, dilated ureters, or hydronephrosis. In many instances, a unilateral small kidney causing hypertension may be a sequela of unrecognized vesicoureteric reflux.

Selective renal arteriography should be considered in any child without evidence of parenchymal renal disease if there is a unilateral small kidney, delayed appearance of dye on a rapid-sequence intravenous urogram, systolic-diastolic abdominal bruit, history of trauma, or neurofibromatosis. Bilateral renal vein renins should be performed if arteriography shows a stenotic lesion of the main renal artery or one of its branches. An aortogram should be obtained in infants with unexplained hypertension.

Primary Hypertension in Childhood

It now is believed that the roots of primary hypertension in adults begin in childhood. Since blood pressure appears to "track" through childhood and early adolescence, it has been surmised, though not yet proven, that tracking continues into adulthood. Thus, children with "high normal" blood pressure, tracking near the 95th percentile, may be destined to become the adult hypertensives of the future. Early detection will identify "at risk" individuals and keep them under surveillance until blood pressure elevation reaches a level warranting therapeutic intervention.

In recent years, unexplained hypertension has been recognized increasingly in adolescents and primary hypertension may account for up to one half of hypertension in this age group. Nevertheless, secondary hypertension always should be ruled out before concluding that the teenager has primary hypertension.

Primary hypertension should not be diagnosed on the basis of a single borderline blood pressure measurement. Unless there is unequivocal hypertension of a moderate degree, the variability of blood pressure measurements in adolescents is high, and repeated measurements should be obtained. Until this is done, one should avoid labeling an adolescent as "hypertensive," so as to obviate later problems regarding acquisition of a driver's license, occupation, insurability, and participation in sports. It is not clear yet if "labile hypertension" in adolescents is a precursor of sustained hypertension in adults. Nevertheless, although measurements may be variable, definite hypertension requires treatment so as to avoid serious sequelae.⁷

The actual prevalence of essential hypertension in children and adolescents is relatively low (probably less than 1%) compared to the estimate of 20% of the adult population. In one survey of an apparently healthy schoolchild population, a single screening uncovered blood pressure exceeding 140/90 or the 95th percentile in about 13%.⁸ However, this relatively high prevalence declined to 0.6% after three repeated measurements. Of 6,622 children screened, only 12 were ultimately diagnosed as having persistent "primary hypertension." All of them had mild elevation, and none have required pharmacotherapy.

Primary hypertension in children is highly correlated with a positive family history of hypertension. In many children with apparent primary hypertension, obesity also is an important predisposing factor. This probably explains the increasing number of referrals of adolescent athletes who are found to have elevated blood pressure at the time of their preseason physical examination, despite using a blood pressure cuff of appropriate size. In many instances, although the aspiring football lineman

Table 2

Nonrenal Causes of Secondary Hypertension in Children and Adolescents

- I. Adrenal cortical disease
 - A. 11 beta-hydroxylase deficiency
 - B. 17 hydroxylase deficiency
 - C. Primary hyperaldosteronism
 - D. Dexamethasone — suppressible hyperaldosteronism
 - E. Cushing's syndrome
- II. Miscellaneous
 - A. Corticosteroid therapy
 - B. Coarctation of the aorta
 - C. Pheochromocytoma
 - D. Oral contraceptive
 - E. Sipple syndrome
 - F. Liddle syndrome

often appears heavily muscled, he actually may be somewhat overweight.

Treatment

Although weight reduction, limitation of salt intake, or active dynamic exercise (walking, jogging, swimming) are useful first steps in controlling mild hypertension, drug therapy may be indicated if hypertension persists. In one study, weight reduction normalized blood pressure in obese individuals with hypertension.⁸ Treatment is indicated especially if there is a strong family history of primary hypertension, evidence of target-organ involvement, ie, retinal arteriolar constriction, left ventricular hypertrophy, etc., and if blood pressure consistently exceeds the 95th percentile by 10 to 20 mmHg. Since most adolescents with primary hypertension are asymptomatic, motivation to adhere to a treatment program requires education, review of risk factors, and frequent follow-up. Compliance with pharmacotherapy may be facilitated by using medications having a long duration of action, thereby avoiding a divided dosage schedule. Changing a sedentary life style by undertaking dynamic exercise should be encouraged. However, body-building exercises, such as weight lifting, do not contribute to lowering blood pressure and, in fact, may lead to raising it during exertion.

The goal of treatment is to lower blood pressure to the 95th percentile or less. The initial medication, as the first phase of a "stepped care" approach, should be a diuretic agent.¹ A long-acting preparation, such as chlorthalidone is preferable. Since many adolescents have blood pressure elevation in association with a hyperadrenergic circulatory state, a beta blocker such as propranolol often is a suitable second-step medication if a diuretic alone is not sufficient. Treatment with propranolol does not preclude active participation in sports. In fact, such participation should be encouraged, provided hypertension is well controlled without side effects from treatment. If there is any question about this, the prospective athlete should have a stress test while receiving medication.

Long-term compliance with a treatment program, especially by teenagers who perceive themselves as being well because they do not have symptoms, remains a vexing problem. Nevertheless, although home measurements of blood pressure are useful, regular office examinations should be maintained to assure compliance and reinforce education. Counseling of such teenagers should not be heavy-handed or intimidating; rather, frequent office visits providing support and positive reinforcement are more effective.

Periodic Preventative Maintenance

The Task Force recommends that all children have blood pressure measured yearly, as part of their ongoing

care, beginning at 3 years of age.¹ The blood pressure should be plotted on the Task Force graph. Graphs may be obtained from the National High Blood Pressure Education Program (120/80 National Institutes of Health, Bethesda, MD 20014) and from the Mead Johnson Company (Evansville, Indiana).

Routine preventative maintenance also should include measurement of height and weight, a yearly urinalysis, and in girls, at least one urine culture before entering school.

Summary

Blood pressure can be measured accurately in young children and adolescents, provided a cuff of proper size is used. This is important especially in obese individuals. A secondary cause of hypertension is most likely to be found in a young child with hypertension. Although secondary hypertension also is common in adolescents, borderline or mild blood pressure elevation may be an early clue to primary hypertension, especially if there is obesity or a positive family history. There is no one single cutoff level for defining hypertension in children. The best index is the 95th percentile of the blood pressure distribution for that age.

References

1. Task Force on Blood Pressure Control in Children. Report. *Pediatrics* (Part 2 or Supplement) 59(5):792-820, 1977.
2. Steinfeld L, Dimich I, Reder R, et al: Sphygmomanometry in the pediatric patient. *J Pediatr* 92:934-938, 1978.
3. Reder RF, Dimich I, Cohen ML, et al: Evaluating indirect blood pressure measurement techniques: A comparison of three systems in infants and children. *Pediatrics* 62:326-330, 1978.
4. Park MK, Kawabori I, Guntheroth WG: Need for an improved standard for blood pressure cuff size. The size should be related to the diameter of the arm. *Clin Pediatr* 15:784-787, 1976.
5. Chiang BN, Perlman LV, Epstein FH: Overweight and hypertension. A review. *Circulation* 39:403-421, 1969.
6. Steinfeld L, Alexander H, Cohen ML: Editorial: Updating sphygmomanometry. *Am J Cardiol* 33:107-110, 1974.
7. Heyden S, Bartel AG, Hames CG, et al: Elevated blood pressure levels in adolescents, Evans County, Georgia. Seven year follow-up of 30 patients and 30 controls. *JAMA* 209:1683-1689, 1969.
8. Rames LK, Clarke WR, Connor WE, et al: Normal blood pressures and the evaluation of sustained blood pressure elevation in childhood: The Muscatine study. *Pediatrics* 6:245-251, 1978. ☆☆☆

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STATE

OPTOMETRIC DRUG BILL STOPPED ONCE AGAIN

The Ohio State Medical Association and the Ohio Ophthalmological Society have again succeeded in blocking legislation which would permit nonmedically trained optometrists to administer potentially dangerous drugs. The Ohio Optometric Association has withdrawn its support of House Bill 158, ending any further action on the bill this session. In their letter to Representative Ed Orlett, (D-Dayton) sponsor of HB 158, the Ohio Optometric Association cites the continued opposition to the bill by the Ohio State Medical Association and the Ohio Ophthalmological Association, along with the threat of another veto by Governor James A. Rhodes as the reasons they withdrew their support of the legislation.

On December 15, 1978, Governor Rhodes vetoed a similar optometric drug bill, Senate Bill 163, citing in his veto message: "The matter of health care is a vital concern and we must insure to all Ohio citizens that they will receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes could bring tragic and irreversible results."

The OSMA and the Ohio Ophthalmological Society have maintained strong opposition to optometric drug legislation which still does not provide adequate pharmaceutical education and training for nonmedically trained optometrists. More importantly, HB 158 does not provide for any referral mechanism for patients with potential pathological conditions which require the care of appropriately trained medical specialists. The Ohio Optometric Association refuses to recognize the necessity to include this safeguard in any optometric drug legislation despite the fact that optometrists are not adequately trained to diagnose or treat disease.

Governor Rhodes in his veto message illustrated the importance of education and cooperation between optometrists and the medical profession: "Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio's citizens. If the individuals involved (optometrists) were properly trained, this procedure (diagnostic pharmaceutical agents for optometrists) would be in the best interests of Ohio's citizens. However, without proper training, the bill would allow an unwarranted risk without correspond-

ing benefits. The drugs involved are dangerous and have the potential of causing a great deal of pain including blindness."

The withdrawal of support by the Ohio Optometric Association makes it doubtful that HB 158 will receive further consideration this session. This type of legislation will undoubtedly appear next session in a similar form.

ATTORNEY GENERAL SUES CLEVELAND HOSPITALS

The Greater Cleveland Hospital Association (GCHA) is the target of a new antitrust suit filed by Ohio Attorney General William J. Brown. The suit, filed on July 25, alleges that GCHA has conspired to restrain competition among its 51 member hospitals. GCHA's member hospitals are located in Cuyahoga and surrounding counties.

At his press conference announcing the suit, Attorney General Brown, who has indicated his intention to run for the office of governor in 1982, claimed that the association is a "cartel that is conspiring to keep prices high." Brown stated that hospital rates in Cuyahoga County are 23% higher than the national average, that Blue Cross of Northeast Ohio premiums for coverage to supplement Medicare are 68% higher than those premiums in the Cincinnati area, and that nongroup insurance premiums of Blue Cross of Northeast Ohio have risen 77% from 1976 to 1979. Brown claimed that the higher insurance rates in the Cleveland area are the result of higher hospital rates, which in turn result from a conspiracy among Cleveland hospitals to restrain competition.

Brown attacked "cost-based pricing" by hospitals as an "inherently inflationary" reimbursement mechanism which rewards inefficient operations. The suit alleges that "cost-based pricing reverses ordinary economic incentives and insulates hospitals from the pressure of competition."

HOSPITAL COST INCREASES TO BE MONITORED

Alfred E. Kahn, Chairman of the Council on Wage and Price Stability, announced on June 9 that the council, on the recommendation of its price advisory committee, will begin monitoring increases in health care costs. The task has been delegated to the Health and Human Services Department, but HHS had been dragging its feet on issuing cost guidelines. Specifically, the council will track increases in individual hospital costs and physician fees by specialty. A day later, Kahn announced a four-point plan to cut back on federal financial support for hospital construction.

FEDERAL

OSMA KEY PHYSICIAN AND AUXILIARY CONTACTS HELP STOP UNNECESSARY FEDERAL REGULATIONS

In a stunning defeat for Senators Kennedy and Javits, the U.S. Senate passed legislation designed to improve the protection and services mental health patients receive, without the controversial Title III, S 1177, known as the Mental Health Systems Act, was amended by Senator Robert Morgan (D-N.C.) to delete Title III. That title provided a mandated Federal "bill of rights" for the mentally ill and mentally handicapped. The Morgan amendment was accepted after considerable lobbying by several groups, including the Ohio State Medical Association, the American Medical Association, the American Psychiatric Association and Ohio Department of Mental Health and Mental Retardation Director Timothy Moritz, M.D.

The "bill of rights" provided in S 1177 was strongly supported by Senators Javits (R-N.Y.) and Kennedy (D-Mass.). Both Senators promised the defeat of the entire bill should Title III be deleted. The Morgan amendment drew strong support as it became clear the "bill of rights" would be superfluous in the 35 states, such as Ohio, that have a strong patient "bill of rights" statute.

The bill makes major improvements in the existing Federal mental health programs. Following the OSMA Legislative Alert, Ohio physicians and Auxiliaries contacted Ohio's Senators to let them know of OSMA's position. The active participation of OSMA's key physicians and Auxiliaries was critical in the amending of S 1177.

HCFA PROJECTS 300% INCREASE IN HEALTH CARE COSTS

If current spending patterns persist, reported the Health Care Financing Administration, the nation's annual health care costs will triple over the next decade, from \$245 billion in 1978 to \$758 billion in 1990. Per-person expenditures will increase over the same period from \$863 to more than \$3,000. The cost of physician services, the report estimates, will rise from \$35.3 billion to \$128.8 billion. HCFA used the occasion to reemphasize the need for hospital cost containment legislation. Without the bill, they said, annual hospital costs are expected to jump from \$76 billion in 1978 to \$334.6 billion in 1990.

HHS ISSUES MORE REGULATIONS

The Health and Human Services Department has agreed to extend its participation in Maryland's rate-setting program for another three years by granting a waiver under Medicare and Medicaid and letting the state's hospital cost review commission determine reimbursement rates. On another front, the department has issued regulations that require nursing homes to guarantee specific rights to individual patients — privacy and visitation rights, for example. Institutions not complying with the new "bill of rights," estimated to cost \$80 million, would face losing their Medicare and Medicaid funds.

MEDICAL RECORDS BILL MOVING IN HOUSE

The House Interstate and Foreign Commerce Committee approved a bill to protect the privacy of medical records kept by hospitals and other health care facilities. Under the bill (HR 5935), medical facilities would have to restrict the disclosure of medical information both with and without a patient's consent. In addition, patients could inspect their records and correct mistakes in them. Jurisdiction over the bill is shared by three House committees. The Government Operations Committee has already cleared a similar bill, but the Ways and Means Committee has yet to begin acting.

SUPPLY OF PHYSICIANS INCREASING

By 1990, according to a report released by the Health, Education, and Welfare Department, the nation's supply of doctors will approach 600,000. According to this report, this is an adequate, and possibly excessive, number. Between 1970 and 1978, the number of physicians increased by 17%, from 323,000 to 379,000. Over the same period, the number of pharmacists increased by 14%, dentists by 19%, and veterinarians by 32%. The findings should help bolster the Administration's efforts on Capitol Hill to eliminate capitation payments to medical schools to subsidize enrollment.

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Karen S. Edwards

In the first of a two-part series of interviews for "On Record," OSU Marketing Professor, Roger Blackwell, Ph.D., takes a look at the changing role of the physician in the 1980s. This month, Dr. Blackwell discusses the influences that are challenging the physician's role as captain of the health-care team.

Reflections in a Diamond Year 481

Richard L. Meiling, M.D.

This summer marks the 75th year of publishing for the Ohio State Medical Journal. The Journal's Consulting Medical Editor takes a historic look at the way we were . . . and the way we are today.

The Committees 485

OSMA Staff

The assortment of OSMA committees provides a grass-roots level of involvement for the physician interested in organized medicine. This special feature reviews the purpose of each OSMA Committee, and lists the incumbent committee members, as well as the new ones appointed by OSMA President, Robert G. Thomas, M.D.

A Different Welcome 495

Karen S. Edwards

Carlos Andarsio, M.D., a Springfield proctologist, felt he owed his native Cuba "a lot," so he recently volunteered his medical services at a Cuban refugee camp, outside Eglin Air Force Base, Florida. Here is the story of his experiences at the camp, and the emotional chaos it awakened in him.

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Our Cover

Warren W. Smith, M.D., Columbus, took an "Outstanding Entry" in this year's *Journal* photographic contest with his picture of "Pelicans, Keywest." Dr. Smith used a Pentax ESII camera with an 85 mm lens. The picture was taken in the morning, using Kodachrome 64 film.

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JAMES ALLEN, M.D., Gahanna, was appointed as Jefferson Township Fire Department's medic advisor. Dr. Allen has been employed for the past 8 years by Emergency Services Incorporated, a group of 11 physicians serving Mt. Carmel East and Mt. Carmel Medical Center.

LEONARD P. CACCAMO, M.D., Youngstown, was reelected chairman of the board of trustees of Northeastern Ohio Universities College of Medicine, and **JAMES E. FLEMING, M.D.**, Cleveland, was reappointed vice chairman.

JOHN J. CAHILL, M.D., Willoughby, was elected to the board of directors of the Ohio Chapter of the American College of Emergency Physicians. The Ohio Chapter is the second largest of all state chapters in ACEP.

RALPH DePALMA, M.D., Cleveland Heights, was appointed professor and chairman of the department of surgery at the University of Nevada.

WILLIAM DOWNING, M.D., Lake County, was elected president of the Pasteur Club. The club recognizes physicians for outstanding ability and contribution to the field of medicine in the Cleveland area.

Dr. Downing, a candidate for Lake County commissioner, is past president of Lake County Chamber of Commerce, United Way and Rotary Club, chairman of Lake County Hospital trustees and a director of Lake National Bank.

ATIS K. FREIMANIS, M.D., Columbus, was elected to the Council of the Society of Chairmen of Academic Radiology Departments.

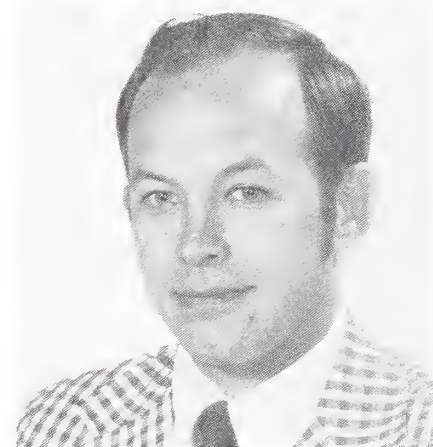
THOMAS R. FRYE, M.D., Columbus, was elected to the Radiological Fellowship in the American Academy of Pediatrics. Dr. Frye is clinical professor of radiology and pediatrics at Ohio State University, and chief of the department of radiology at Children's Hospital.

WESLEY FURSTE, M.D., Columbus, was elected to the Board of Governors of the American College of Surgeons.

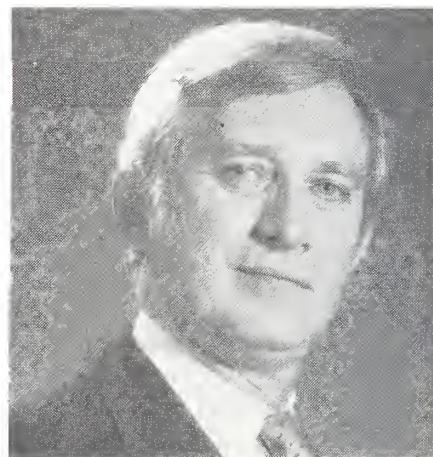
HELOUISE C. MAPA, M.D., East Liverpool, was elected to Associate Fellowship in the American Academy of Pediatrics. Dr. Mapa is an attending physician at City Hospital.



Frank H. Mayfield M.D. . . . AMA's 1980 Distinguished Service Award recipient.



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ALBERT MAY, M.D., Marion, was appointed a member of the Committee on Education of the Ohio State University Medical Association. The committee is responsible for the accreditation of hospitals and other health care institutions in the area of continuing education.

The American Medical Association's 1980 Distinguished Service Award was presented to **FRANK H. MAYFIELD, M.D.**, Cincinnati.

Dr. Mayfield, a neurosurgeon, was chosen for the honor by the AMA House of Delegates during the 1979 Interim Meeting in Honolulu.

Dr. Mayfield is a former president of OSMA and former chairman of the Ohio Medical Political Action Committee. He was president of both the Society of Neurological Surgeons and the Harvey Cushing Society (American Assn. of Neurological Surgeons).

He was a member of the American College of Surgeons Board of Governors and chairman of the American Board of Neurological Surgery. An AMA delegate from 1971 to 1976, Dr. Mayfield was a member of the AMA Interspecialty Advisory Board.

He received the American Board of Neurological Surgery's distinguished service award, and in 1977 he was the recipient of the Cushing Medal of the American Assn. of Neurological Surgeons.

ROBERT T. MCKINLAY, M.D., Westerville, was elected chairman of the Medical Advisory Committee of The Ohio Society to Prevent Blindness.

JOHN MEAGHER, M.D., Columbus, was appointed to a six-year term on the American Board of Neurologic Surgery. Dr. Meagher is clinical professor of surgery at Ohio State University and was inducted recently as president of the Neurosurgical Society of America.

VICTOR MORANT, M.D., Cleveland, was elected to the Board of Trustees of the Northeast Ohio Affiliate of the American Heart Association. Dr. Morant is active with the Heart Association as a member of the Advanced Cardiac Life Support Affiliate Faculty, and is associated with the Cleveland Clinic.

ROBERT J. MURPHY, M.D., Columbus, was the speaker at the Rotary Club luncheon the week of June 9. His topic was Sports Medicine—1980. Dr. Murphy is the head team physician for the Athletic Department at OSU.

LARRY C. CAREY, M.D., Columbus, was installed as president of the Society for Surgery of the Alimentary Tract.

Dr. Carey is professor and chairman of the department of surgery at Ohio State University. He is the author of many scientific papers and is active in several national surgical societies. He is also president-elect of the Ohio Chapter of the American College of Surgeons.

SIDNEY W. NELSON, M.D., Columbus, was honored at the annual meeting of the Association of University Radiologists. The Association awarded a Gold Medal to Dr. Nelson who also is a founder and former president of the organization.

JAMES L. REINGLASS, M.D., Canton, and **SAMUEL CATALAND, M.D.**, Columbus, were elected to Fellowship in the American College of Physicians.

CARRIE KREWSON SCHOPF, M.D., Lakewood, was appointed Lakewood health commissioner. Dr. Schopf will direct the city's health department and will serve on the Lakewood Hospital board of trustees.

DAVID E. SCHULLER, M.D., Columbus, was declared a Fellow of the American Academy of Facial Plastic and Reconstructive Surgery.

VICKIE ANN WHITACRE, M.D., Zanesville, was elected to the board of directors of the Ohio Chapter of the American College of Emergency Physicians. Dr. Whitacre is the director of emergency physicians at Bethesda Hospital.

SAMUEL GROSS, M.D., Moreland Hills, was elected vice president of Children's Oncology Services of Northeastern Ohio, Inc., a nonprofit corporation which owns and operates the Ronald McDonald House.

Dr. Gross is director of pediatric hematology/oncology at Rainbow Babies & Children's Hospital, and professor of pediatrics at the Case Western Reserve University School of Medicine.



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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Karen S. Edwards

Viet vet program needs volunteers

The Veterans Administration is establishing a roster of private psychiatrists, psychologists, and social workers interested in part-time volunteer work in the nationwide network of Vietnam Era readjustment counseling centers recently established in various cities across the country.

The professionals on the register would be called on to assist the staffs of the small vet centers already set up in nearly 100 localities to aid young veterans who have experienced readjustment problems since leaving military service.

Donald Crawford, M.D., director of the VA outreach program, said the volunteers are needed to augment vet

center personnel who, in some instances, have been swamped with requests from veterans for assistance.

He emphasized that those interested in participating in the program should themselves be Vietnam Era veterans or have a demonstrated empathy toward this veteran group and the long-term readjustment problems being experienced by a number of its members.

Individuals wishing additional information on the vet center volunteer consultant program should contact Dr. Arthur Blank, Operation Outreach, Psychiatry Service (116A), VA Medical Center, West Haven, CT. 06516. **OSMA**

MISCELLANEA

The American Psychiatric Association is offering a new 16-hour **Survey of Psychiatry** review course for psychiatrists who wish to keep themselves abreast of current trends. The program, recorded on 14 audiocassettes, spans a wide range of topics, including Forensic Psychiatry;

The Schizophrenias and Borderline Disorders, and Clinical Psychopharmacology. The course has been approved for up to 16 hours of CME Category I credit. For more information, contact Ms. Dorine Kitay, (800) 221-4468. **OSMA**

Ohio State Medical Golfers announce tournament winners

William M. Emery, M.D., Ashland, and Charles J. Burns, M.D., Lima, tied for low gross honors with scores of 78 at this year's Ohio State Medical Golfers Association Tournament, held June 13 at Mansfield's Westbrook Country Club.

Donald M. Beddard, M.D., Mansfield, captured low net honors with a 64 (80-16 handicap).

Winners in age flights were:

Age 39 and Under

Low gross — Albert J. Hart, Jr., M.D., Westerville (80)

Low Net — David M. Montgomery, M.D., Canton (70)

Age 49 and Under

Low gross — Ralph R. Ballenger, M.D., Columbus (79)

Low net — Robert E. Sooy, M.D., Kettering (69)

Age 59 and Under

Low gross — David M. Bell, M.D., Cleveland (79) and
Russell P. Rizzon, M.D., Cleveland (79)

Low net — Richard B. Belt, M.D., Mansfield (67) and
Russell R. Rizzo, M.D., Cleveland (67)

Age 69 and Under

Low gross — C. T. Kasmersky, M.D., Columbus (85) and
Robert E. Tschantz, M.D., Canton (85)

Low Net — P.S. Test, M.D., Mansfield (66)

Age 70 and Over

Low gross — Robert C. Kirk, M.D., Columbus (90)

Low net — Gilman D. Kirk, M.D., Columbus (69)



Donald N. Beddard, M.D., Mansfield, demonstrates the putting style that helped him capture low net honors in the 1980 Ohio State Medical Golfers Association Tournament.

Meetings

"Fourth National Conference on the Impaired Physician," October 29-November 1, Lord Baltimore Hotel, Baltimore, Md. Sponsor: AMA Department of Mental Health, and the Medical and Chirurgical Faculty of Maryland. The conference will focus on all aspects of impairment, including prevention. Contact: The Department of Mental Health, AMA, 535 N. Dearborn St., Chicago, IL., 60610.

"Gastrointestinal Cancer," November 5-7, Shamrock Hilton Hotel, Houston, Texas. This conference will focus on all of the major gastrointestinal cancers. Contact: Stephen C. Stuyck, Information Coordinator, M.D. Anderson Hospital and Tumor Institute, Houston, Texas 77030, 713-792-3030.

"The Evaluation and Current Treatment of Athletic Injuries —The Team Approach," December 4-6, Hyatt Regency, Houston, Texas. Sponsor: The Sports Medicine Section of the American Physical Therapy Association in association with the Sports Medicine Institute of the University of Cincinnati. Credit: 16 hours, Category I. Contact: Robert Mangine, Department of Physical Therapy, Medical College of Virginia, Box 224, Richmond, Va. 23298.

"Care of the Seriously Ill Child," October 1-2, Indianapolis Hilton Hotel on the Circle, Indianapolis, Indiana. Sponsor: Indiana University School of Medicine. The program will describe current concepts of care regarding such topics as infectious disease, childhood cancer, and rheumatology. Contact Jay L. Grosfeld, M.D., Surgeon-in-Chief, Whitcomb Riley Hospital for Children, 1100 West Michigan Street, Indianapolis, Indiana 46223.

"Neurology for Non-Neurologist," December 10-12; Sheraton Plaza Hotel, Chicago, Illinois; Sponsor: Rush-Presbyterian-St. Luke's Medical Center. A practical review of neurologic conditions commonly encountered in clinical practice. The program is designed for family practitioners, general practitioners, internists and psychiatrists; 20 hours Category I credit. Contact: Jennifer Littleton, Office of Continuing Education, Rush-Presbyterian-St. Luke's Medical Center, 600 South Paulina Street, Chicago, Illinois 60612. **OSMA**

Migrant health



Mercy's Dr. Jack Baron visits with a patient at the Migrant Health Clinic at St. Charles Hospital.

Moving from place to place, following the planting and harvesting of crops, migrant agricultural families are frequently unable to obtain adequate medical care.

To help improve the situation, Mercy Hospital Family Practice residents from Toledo have agreed, for the sixth year, to supply manpower to the Migrant

Health Clinics located in Oregon, Ohio.

The Clinic's personnel work closely with the physician residents, using their suggestions for new process and equipment needs to provide better, more effective care of the migrants. **OSMA**



Read any good books lately?

This spring, Riverside Hospital in Columbus opened its new \$1.5 million Library Resource Center, one of the largest community hospital libraries in the country.

The Center, which holds 10,000 books and 12,000 bound journals, also

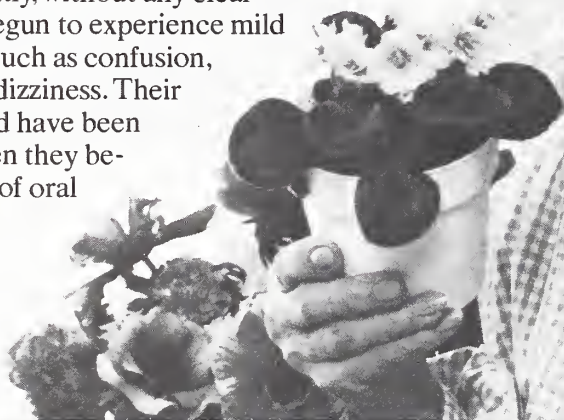
features two computerized reference systems, audiovisual materials, a patient education area, and the ability to obtain materials from across the country through an interlibrary loan system. **OSMA**

more news on page 470

The primary beneficiaries of ORAL HYDERGINE[®] TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro- α -ergocryptine and dihydro- β -ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500.

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Before prescribing, see package insert for full product information.

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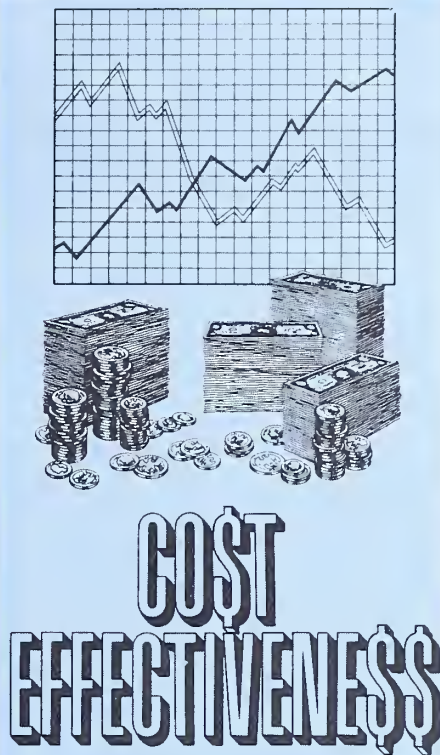


The emergency physician's contacts with patients are by nature brief and episodic. Because many of the complaints are secondary to trauma, and because of many other complex factors revolving around the nature of emergency medicine and the litigious nature of our society, the emergency physician often feels pressured into ordering an excessive number of diagnostic tests. The resultant expense to the patient and to society can be enormous. In our hospital, for example, the average total fee for the average patient is approximately \$85 (includes hospital charges). Although the majority of tests are necessary and appropriate, there is some room for selectivity on the part of the ordering physician.

The privileges and rights afforded a physician by virtue of his training and experience are many. They include wealth and public esteem. All too often, however, we forget the obligations and burdens that society rightfully expects us to bear in exchange for these rights and privileges. Among others, I believe we have a responsibility to be as cost conscious as possible without subjecting the patient in a significant way to increased morbidity and mortality. I believe we have an obligation to practice cost effective medicine, as well as an obligation to defend what we believe in a court of law. After all, that is where the overall relationship between society and medicine is established. I am not asking physicians to welcome suits, but I am asking that they not attempt to shirk their responsibility to practice cost effective medicine by transferring that burden to society by virtue of excessive "medicolegal" testing.

Many physicians will practice good medicine based on scientific evidence. They will, however, practice "medicolegal defensive medicine" based on hearsay evidence. For example, medical decisions may be based on careful double-blind studies based on literature whereas "medicolegal" decisions may be based on antidotal information which is probably unsubstantiated. There is an

August 1980



Cost Effectiveness and the Emergency Physician

By Bruce D. Janiak, M.D.

inappropriate assumption of a medicolegal cause and effect leading to excessive and inappropriate testing.

What ways then can an emergency physician attempt to be more cost effective without endangering himself or the patient significantly? First of all, have some idea how much cost you are inflicting on the patient. Look up your hospital's charges for various commonly ordered x-rays and laboratory work. An accurate knowledge of charges will stimulate you to think twice before you order certain tests.

Second, record an accurate history and physical on the chart in a legible manner. All the x-rays and tests in the world won't help if you have a grossly inadequate history and physical examination. Examine carefully the benefits of having your emergency records dictated and typed.

Third, treat the patient with dignity and respect. Litigious thoughts grow easily in the mind of a patient who perceives you as rude and disrespectful.

Fourth, order only the tests you need. A common error is for a CBC to be ordered when the physician, in reality, is interested only in the level of the hemoglobin, the hematocrit or the white blood count. Most laboratories run the H&H and WBC on the Coulter counter for a certain reduced charge. The differential which is usually included in a "CBC," requires an additional charge because the slide must be stained and interpreted by the technician. When you have no desire to know the percentage of segs or lymphocytes, there is no reason to expect the patient to pay for this information. Patients with vaginal bleeding and blunt abdominal trauma commonly are subjected to these extra charges.

Fifth, order only the x-rays you need. There has been much literature in recent years about the cost-effective ordering of skull x-rays. More recently, articles have appeared in rebuttal citing cases that have been missed when cost-effect criteria are strictly adhered to. Nonetheless, it is probably inappropriate to have so much

emphasis on the x-rays and decreased emphasis on the patient.

Whatever your philosophy, read the literature and establish your own criteria for ordering these films, keeping in mind that an adequate neurologic examination recorded on the chart is a much better defense than the indiscriminate ordering of films. I am aware that neurosurgeons have made statements in textbooks and articles on head trauma, stating that all patients with head trauma should have skull films. I regard these statements as grossly unrealistic and irresponsible.

Also, x-rays of the midshaft, humerus, and femur often are unnecessary. We see many patients with blunt injuries to the midshaft of the humerus and femur. A simple evaluation of this area by producing lateral and medial, anterior and posterior stress over the midshaft of the bone must be done. If these maneuvers do not produce any significant amount of pain, if there is no swelling or deformity and if, in the case of the femur, the patient can ambulate, then it would not be reasonable to order a film.

Another example is the suspected single rib fracture. Patients with relatively minor blunt chest injury who have clear chests and some inspiratory pain may not always need x-rays of the ribs. Single rib fractures do not have to be aggressively treated. However, if you feel you must get an x-ray, why not x-ray for the reasonable complications of a rib fracture such as pneumothorax and pulmonary contusion or hemorrhage? I would suggest inspiratory and expiratory chest x-rays rather than rib films to locate an isolated rib fracture.

There seems to be no reason to take an x-ray of a tender, swollen toe that does not exhibit deformity. As long as there is no metatarsal pain and you feel the patient does not have a dislocation, and you recognize that treatment for a fracture would also benefit a sprain, there is no reason whatsoever to order toe films.

"Fine," you say, "very idealistic!" but what about the real world where concerned and/or angry parents "demand" an x-ray or test? "What do I do then?"

Then, Doctor, you must employ old fashioned bedside manner to its fullest. Explain your reasoning, the pros and cons of the test in question, and why, **in your judgment**, you do not wish to subject the patient to a needless procedure. In my experience, parents and relatives are surprised you will take the time to discuss such matters in detail, and will respect your judgment.

In conclusion, malpractice worries, pressures from ill-informed patients and relatives, and physician insecurity have combined to create a false "standard of care," especially in the emergency service. This false standard is responsible for millions of wasted health care dollars yearly. It is our responsibility as emergency physicians to reverse this trend. The public expects this of us. **OSMA**

Bruce D. Janiak, M.D., is Director of the Department of Emergency Medicine at the Toledo Hospital.

NEWS

Continued from page 467

Child abuse prevention month

August has been proclaimed "Child Abuse and Neglect Prevention Awareness Month" in Ohio by Governor James A. Rhodes.

In keeping with the observance the Ohio Department of Public Welfare has developed a kit on the prevention and reporting of child abuse and neglect. Each kit contains inserts which explain the physical, behavioral, and environmental characteristics of children and families where abuse and neglect may have occurred. Kits also contain medical indicators, interviewing techniques, and excerpts from Ohio's reporting law.

Since medical professionals are often the first to observe abused and neglected children, kits are being made available, free, to Ohio physicians. To order the kits, write: Office of Public Information, Ohio Department of Public Welfare, 30 E. Broad St., 32nd Floor, Columbus, Ohio 43215; or call, 1-800-282-1190 (in Columbus, call 466-6650). **OSMA**

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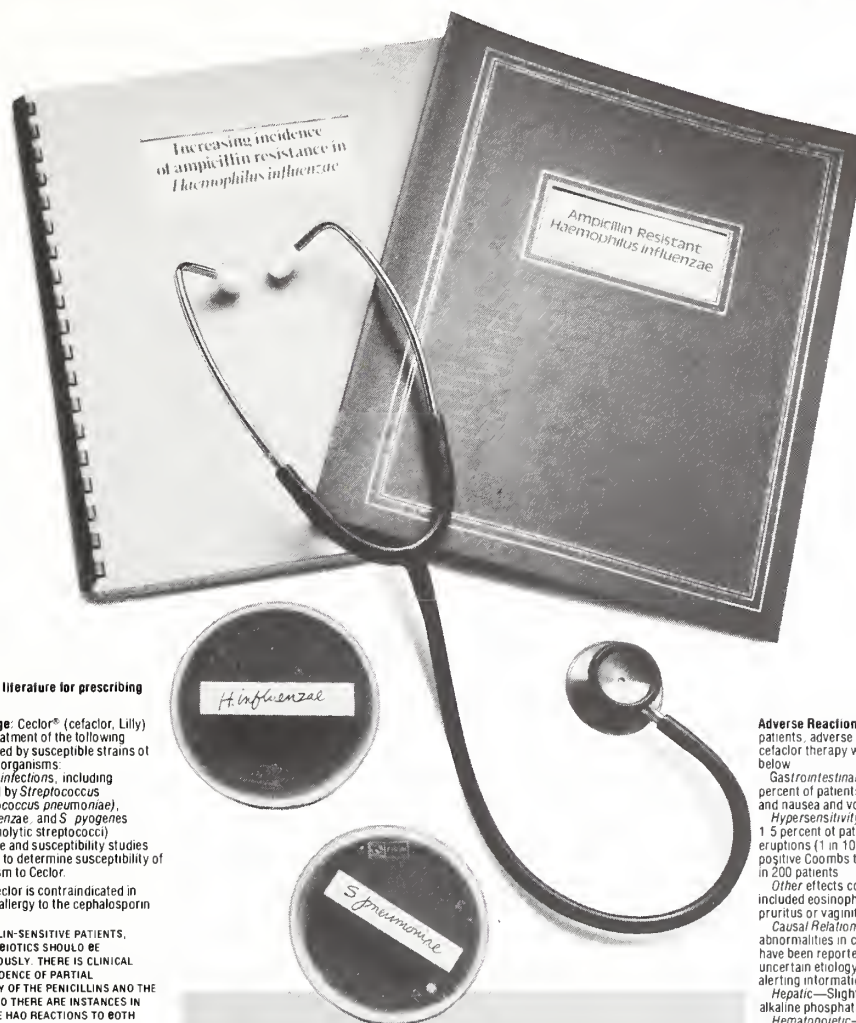
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed in the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0703759]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C., American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



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SECOND OPINION

The American Medical School: An ailing business in the 1980s

By Eugene D. Jacobson, M.D.

Editor's Note

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

The 1960s and 1970s were periods of unprecedented growth for academic medical institutions. During that time, the number of schools increased 50 percent, the number of faculty members and graduating students doubled, and the size of budgets and value of capital plant increased manyfold. The amazing fact is that the quality of American schools **improved** during this era of expansion, in terms of the intensity and variety of new research, educational and practice activities; higher qualifications of both students and faculty; improved hospital, laboratory and classroom facilities; and heightened awareness and commitment to social obligations. There are ample signs that the 1980s will witness retrenchment of this multibillion dollar industry but the question is whether our medical schools will be able to **sustain** contraction without sacrificing quality.

This decade, the forces pressing each school into an ever more precarious posture will be the economic, social and political imperatives of a nation which ordered the recent growth. The price paid by the American medical school for its new found affluence and size was dependence upon the public largesse. That dependence has been cemented by economic and legal mortar and probably cannot be dissolved.

Expanding Economy

Although this country is wealthy, economic forecasts are not optimistic. The growth in real gross national product and in productivity averaged less than 3% annually in the 1970s and these parameters are projected to show

slower growth this decade. The inflation rate in health care costs has risen more abruptly than the general inflation rate. Increases in technology, public use of hospitals and clinics, delivery of health care, professional providers and administrators, and the evolution of widespread third-party payment are the major factors which tripled the cost of American medicine over the past decade. Each American now expends an average \$1,000 annually for national medical services, whether or not he or she uses them.

Medical schools of the past decades were sites for research which created expensive technology or tested those procedures which lent legitimacy to them. Faculties in university hospitals made great use of laboratory tests, extolled the scientific side of medical practice, and emphasized the specialist as the role model for students and residents.

While such characteristics may be appropriate for the faculty of an academic center, they inculcate expensive habits in those physicians leaving the school to enter society. In efforts to contain rising costs of a health-care system they must fund, the federal and state governments have implemented numerous laws and rules. Aside from the questionable constitutionality of trying to restrict the economic freedom and professional practice of more than a half million physicians, the government's effort to control costs at this level would not be easy to implement for logistical reasons alone.

A far smaller target and one already in government's pocket is represented by our 125 medical schools.

Regulations designed to restrict these cradles of physician manpower are more likely to produce a targeted economic impact. Recent examples of such moves to restrict the productivity of medical schools include curtailment of capital funds for construction, reduced capitation funds, slowed growth rate in research monies, and threats to implement regulations reducing federal payment for rendered medical services.

While the private practitioner still operates in the mode of the private medical market, and is relatively safe from governmental regulators, his medical school is predominantly controlled by economic and legal realities of collective socialization. That system has embarked upon a course destined to shrink the academic medical centers.

Caught in the crunch between erosive forces of inflation and waning growth of governmental support, the American medical school enters the 1980s with a justifiably anxious outlook.

Then And Now

Decades ago the faculty of a medical school provided supervision of care to the indigent as a necessary educational and service activity; today that faculty is being called upon to practice medicine in order to generate the funds necessary to float the educational and research activities of the medical school.

Decades ago a small faculty offered a limited lock-step curriculum to a small number of medical students; today a larger faculty must mount a more varied curriculum to many more medical students. Under pressure from the outside, courses in death and dying, prevention of disease, aging, human sexuality, medical parsimony, nutrition and ethics have become part of the growing list of topics for which the faculty has become responsible. Physician assistants, allied health technologists, nurses, graduate students, and postdoctoral fellows have joined the ranks of medical students and residents as recipients of the educational offerings of faculty in a medical school.

Decades ago, a few devoted faculty members worked in laboratories or on the wards to satisfy their curiosity about health and disease through research performed with their own hands; today the faculty member spends much of his time directing a team of technicians and trainees, writing grant applications and progress

reports, and serving on editorial boards, study sections or task forces of professional research organizations.

Within the medical school, a proliferation of committees devoted to regulating human or animal research, promotion and tenure decisions, long-range planning, curricular modifications, and hospital audits consume the time of the academician.

Politicians have found that the economic ills of illness, cost containment, demands for social responsibility of the health industry, research into the frightening diseases of children, and more medical care for more people are popular themes which reflect well upon the public orator speaking to his constituents. Ironically the major result of this government intrusion has been a staggering increase in costs without any commensurate decline in disease over the past decade.

The likely effects of the economic, social and political pressures of the coming decade are apparent. Academic centers will have to reduce efforts in various areas to meet the restrictions of no real growth in revenues. The challenge to leadership will be satisfying public demands without losing the high quality activities of an institution which must educate, conduct research and provide model forms of health care.

Since the faculty of medical schools derives income from government-supported insurance carriers, medical programs, research grants, income and fees for services are likely to come under scrutiny and be closely regulated.

Faculty will have to finance much of the cost of educating students and residents through increased private practice of medicine. While federal grants will still provide a sizable income to schools, this revenue will become a progressively smaller part of the annual budget. This shift to a large group practice mode will bring the institution into economic conflict with affiliated hospitals in the same community.

Pressures Will Be Exerted

Schools will be under pressure to care for, do research upon, and train people in the management of aged patients with chronic illnesses for which there is currently little effective treatment. There will be increasing demand for schools to train fewer professionals with extensive training and more personnel who can deliver

less expensive health care to more people in noninstitutional settings. Education in prevention of illness and counseling may become a required offering of the schools to the public as well as to trainees.

Governmental and large industrial organizations are likely to force competition among physicians and group practices for delivery of health care. In this context the medical school is likely to be exploited because of its structured high overhead associated with educational and research activities.

Pressures will be applied to medical schools to develop guidelines for treatment, diagnostic criteria and algorithms of management which governmental agencies and insurance carriers can use in developing an actuarial approach to fee setting. This role of the school is hardly likely to make it popular with the medical community.

Faculty size will decline. First, there will be less money to support the salaries of individuals not engaged in practice and not funded from grants. Second, there will be fewer students to teach. Third, the medical school will offer a less exciting opportunity than it did during the great period of recent growth. A few of the newer and smaller medical schools will be forced to close. Numbers of house staff will decline. The amount of research will be reduced.

While the preceding picture is tinged in somber colors, there is also a limited opportunity. Fortunes are made when empires rise and when empires fall. The great challenge to medical academia in the 1980s will be the preservation of quality in education, research and health care despite shrinking resources. Some schools will succeed better at this task than others, even as some flowered more beautifully in the last two decades of expansion. **CSMA**

Eugene D. Jacobson, M.D., is an associate dean of the College of Medicine of the University of Cincinnati.

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Editor's Note:

Roger Blackwell, Ph.D., is a professor of marketing at the Ohio State University. His emphasis is in the area of consumer behavior. Dr. Blackwell is the coauthor of a textbook, entitled "Consumer Behavior," which is the number one selling textbook in universities offering credit courses in consumer behavior.

In 1977, Dr. Blackwell and a colleague conducted several research projects for the Ohio State Medical Association's Task Force on Professional Liability. One such project was the development of a consumer attitudes study to measure attitudes of Ohio citizens towards health care and medical malpractice. Two books were written as a result of this study: "Consumer Attitudes Toward Health Care and Medical Malpractice," and "Consumers Speak About Health Care."

Dr. Blackwell is currently consulting with the OSMA Department of Communications to conduct interviews with groups of physicians around the state in an effort to ascertain physician attitudes toward major issues facing medicine.

Information from the interviews will be used to conduct future internal and external communications programs and projects aimed at providing consumers with accurate medical information and improving the image of the medical profession.

Next month "The 1980's Physician: (Part II) from Patient Advocate to Health-Care Captain"

The 1980's Physician: (Part I)

From patient care to patient advocate

By Karen S. Edwards

OSMA JOURNAL: What do you see are some of the major issues facing medicine this decade?

BLACKWELL: In the 1980s it's clear that we're going to be able to do far more in the provision of high-quality health care than we will be willing or able to pay for. One of the major issues, then, is who shall receive the finest of health care, or more directly, who shall determine who shall receive high-quality health care?

The ethic or moral standard of most physicians has been that everyone is entitled to the best of health care. Recently, however, the staff of a major hospital in this country had requests for beginning a major type of surgical procedure, heart transplants specifically, turned down. Not that the

JOURNAL: But since insurance companies generally pay for medication, won't the patient want the best one he can get, despite the cost?

BLACKWELL: That's right. I think the idea of asking the patient to make that decision is probably repugnant to most physicians. However, if physicians are not participants in making that decision, then what they in essence are saying, is that someone else should make that decision. If we say that it's covered by insurance, then we're saying we'll let the third parties make the decision. That position probably is also repugnant to physicians. The dilemma is that the physician must enter into the decision at the patient level or let that decision be made by some other party — government, an

"Physicians are going to have to spend even more time than they are — or even want to — in making moral, ethical, economical decisions."

procedure was medically unfeasible or even undesirable, but rather that it was so expensive they didn't want to start it. There was also no criteria to determine who should receive it and who shouldn't. It's quite possible that in the future, the physician may have to ask his/her patient whether he/she wants a prescription for a medication that will cost \$5 and have an 80% effectiveness rate; or an older, established drug with a 60% effectiveness rate, but which only costs 50 cents.

insurer, or perhaps the employer who determines the insurer. To make no decision is still to make a decision to leave it to someone else.

JOURNAL: How do you think that dilemma will be resolved?

BLACKWELL: Physicians are going to have to spend even more time than they are — or even want to — in making moral, ethical, economical decisions. That will be resisted by many physicians. Medical schools in

The Ohio State Medical Journal

general have provided limited formal education in how to make those decisions. More attention will also have to be paid on these issues by groups such as medical schools, OSMA, and the AMA.

This is something that's not very attractive to most physicians. Most physicians would probably like to spend their time getting on with patient care instead of being involved in those kinds of matters in which they're perhaps not adequately trained which do not usually provide compensation for their time, and which are, in some ways, uncomfortable roles. However, more discussion of these kinds of issues between patient and physician will have to occur. The patient may have to have a better understanding of the physician's view on things such as maximum care. The physician may also have to understand the patient's views.

JOURNAL: Do you think it is the physician's responsibility to make the patient aware of these views?

BLACKWELL: Whether they want it to be or not, physicians are going to have to get involved in that. At one time, we brought to the physician-patient relationship a consensus of values, based on the Judeo-Christian ethic in the U.S. Now, as abortion, euthanasia and other issues illustrate so specifically that consensus of values no longer exists. As a patient being treated by a physician in a life-threatening or long-term relationship, proper questions for the patient to ask would include those that would develop an understanding of the physician's philosophy or value of life. I want to know the importance of life to my physician. And the physician needs to know the value of life to his patient.

It's repulsive to have to stop and ask people, let's think about whether you want maximum care or not, but if the physician doesn't become involved in this issue, then he/she is relegating those decisions to third-party carriers — the government, or someone else on the hospital staff. The physician has a choice either to get involved in those

decisions or leave them to someone else who will make those decisions for the physician.

It's not possible anymore to treat the patient and not worry about who's going to pay. Medicine has become so complex, so technical, and so expensive we're raising issues that can't be handled on a personal level. The physician can't just absorb the costs of a patient where \$2,000 worth of tests are involved as well as many other people's time.

JOURNAL: But doesn't the government step in and pay when a patient can't, thus freeing the physician from having to make that kind of decision?

BLACKWELL: There has been some sort of belief that everyone ought to get good health care, and if they can't afford it, the government ought to pay for it. But the recent Supreme Court decision on abortion, which has many complexities, does lead to the conclusion that the government is not obligated to provide everything for everyone.

JOURNAL: You're saying that physicians are going to have to assume a more active role in moral and ethical issues — that they can no longer just treat the patient and then go home. What's caused this necessity for change in the physician's role? Is technology to be blamed?

BLACKWELL: Technology certainly brings the cost factor directly into the picture and rapidly escalates the change. There are other factors, however. The decline of institutions and the rise of personal ethics have also caused it. We also have to look at the pluralism of society, the foreign-educated doctors who bring their value systems to this country.

JOURNAL: Are you referring to the socialized medical system of Great Britain?

BLACKWELL: Certainly the socialized medicine of European countries, but also the Eastern religious views of the Orient.

Roger Blackwell, Ph.D.





"If the physician wants to remain the captain of the ship of health care, then he/she must carefully analyze where they can use the specialized health care providers, and bring them into the crew of their ship in ways that they are still the captain."

JOURNAL: How will organized medicine affect the practice of medicine in the future?

BLACKWELL: We are evolving into a new society which is much more interdependent in every way. This interdependency puts the control of everything — food, transportation, health care — under the auspices of organizations rather than individuals. Many physicians are still rugged individuals and the esteem and prestige they've had in the community have caused them to have a certain insular position on hospital staffs. The physician's opinion is still valued. As we become more interdependent, however, more and more things become group decisions and proficiency in practice often becomes efficiency in organizations.

That is a situation that has and will continue to be one of great conflict. As we move into an era of more and more

nurse practitioners, more and more specialists, and more and more groups practicing health care, such as weight-loss clinics, we're going to have more and more difficulty with the individual physician being the dominant role. The exigency that threatens to encompass us is that we're dealing with all these diverse interests, and that tends to bring organizations and bureaucracy. The physician must carefully analyze the nature of that environment if he/she is to continue to be the primary patient's advocate.

JOURNAL: So the physician is going to have to start prioritizing organized medicine in his practice?

BLACKWELL: That's right. The first rule of defeating the enemy is understanding your enemy, and understanding that on a carefully organized basis is the prerequisite for the physician to survive in the 1980s as the primary center of interest in the

health care field.

JOURNAL: Do you see the auxiliary medical personnel as a threat to medicine as it's being practiced today?

BLACKWELL: I think there is a considerable danger in the future because everyone who comes from a new, small, unaccepted area has to work harder at developing a power base and they will tend to spend more money, be more enthusiastic and enlist more support from their members for the advocacy of their unique position. That runs the risk of that group becoming more powerful than it should. They need to overstate to make a case. At the same time resistance to that by the traditional interests (as often represented by physicians) can lead to its own dangers — the attempt to crush out things which should be used properly. That conflict can result in great abuses. If the physician wants to remain the captain of the ship of

health care, then he/she must carefully analyze where they can use the specialized health care providers, and bring them into the crew of their ship in ways that they are still the captain. Otherwise, we may end up with a lot of small boats instead of one strong ship.

JOURNAL: How do you see the specialty societies fitting into organized medicine, as represented by the OSMA and the AMA?

BLACKWELL: The most difficult thing for highly technical fields to do is to attain competency in specialties and still retain the larger picture of the generalist. That will be a battle between the specialty groups. If the OSMA and AMA are amalgamations of all those specialty groups, and the groups are well represented in leadership, then there is a possibility of looking at the broader overall view and have satisfying rather than optimizing of any one of the group's objectives. But if those groups are not incorporated into the overall organization, they will go the wrong way and become counterproductive to organized medicine. In order to be effective they will have to overstate their case, and will then be destructive in the same way the auxiliary medical personnel might be.

JOURNAL: Do you see any group becoming stronger than organized medicine as represented by the OSMA and the AMA?

BLACKWELL: I don't believe that at the present time I see the potential of that happening, but many people feel the AMA has changed a lot in the last few years. The question is, do specialists and younger doctors perceive that to be true. . . and is it true? The temptation is for people who have been successful — and have seen the ways that they have followed in the past make them successful — to be very resistant to anything that changes that. But building your future strategies on the things that have made you successful in the past is a sure pathway to demise.

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JOURNAL: Now, consumer interests in health care have recently begun to blossom, and we have the do-it-yourself health care kits on the market. What has brought this about?

BLACKWELL: There are three reasons for the great rise of the black bag and self-health care. One of these is costs, and that's probably the most important. Even those people that have insurance generally do not have insurance that covers calls to the doctor's office. The people who are doing self-health care are what marketing people call the "underprivileged upper classes." That term represents the people with high education, but not high income. They're taking advantage of a lot of these things. You have to remember that more and more people are going to be college educated in the future. The percentage of workers with one or more years of college went from 25% to 37% in the last decade. A second reason for the increase in self-health

of superiority of economic position, social status, and technical information. There is some resistance to that, and a desire for more classlessness in our society. That results in people resenting being treated as a "know nothing." You have to deal with market segments. Many people, maybe not even the majority, feel this way. But the minority who want more information is increasing. That includes information on how to take care of myself.

JOURNAL: But isn't there a sort of self-doubt among consumers as to their adequacy in handling these tests? Don't they want their findings confirmed by a bona fide laboratory, or to hear the diagnosis from a practicing physician and not a nurse practitioner?

BLACKWELL: There's no question that currently the captain of the team is the physician, the one that's most preferred. But his or her position will

"Building your future strategies on the things that have made you successful in the past is a sure pathway to demise."

care is a changing value toward the self as being more important than the group.

JOURNAL: In other words, the "Me Generation" comes into play?

BLACKWELL: Yes. In fact, the "Me Generation" of the 1970s was for the elite. It's increasingly for the masses in the 1980s and Tom Wolfe was right, except it took the 1980s to make it right for large groups. We have a pervasive attitude now to take control of our own life.

The third reason is that there is a certain amount of dissatisfaction with the information and image of physicians. There are still many physicians who bring to the patient-physician relationship a feeling

increasingly be challenged. Whether it will be overturned will be determined to a large degree by the responses of the physicians themselves, today. First and foremost of those things that need to be done would be careful listening or analysis of what those other groups really have to offer. The best way to conquer a subversive group is to bring them into the organization. You have to be able to accommodate views that may not be comfortable or to which you totally agree. Sometimes, the AMA has unfortunately had the image of not accommodating divergent groups. One of the greatest dangers of the traditional groups of medicine would be the failure to examine carefully the small, new groups. To ignore them is to assist them in their struggle for recognition. **OSMA**

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Reflections in a Diamond Year

By Richard L. Meiling, M.D.

"Those who cannot remember the past are condemned to repeat it."

Editor's Note: The Ohio State Medical Journal is now entering its 75th year of publication. The Journal's consulting medical editor, Richard L. Meiling, M.D., takes a historic look at the events leading up to the first issue and at the Journal's place in the Association.

At the time of the Spanish-American War, a dozen young physicians in Cleveland began to speak out for radical changes in medical organizations. Their intention was to establish within the organization a democratic representation of all physician-members, and to eradicate the isolated control by a few older physicians.

As a result of their arguments, the American Medical Association (AMA) appointed a three-member ad hoc "Committee on Reorganization" which included P. Maxwell Foshay, M.D., of Cleveland, then secretary of the Ohio State Medical Society.

The committee developed a plan which would reorganize the AMA based on the county medical societies. According to their plan, local societies would elect from their members delegates to a state legislative body, and the State Medical Society would, in turn, elect members to the AMA's

House of Delegates. Thus, a federation of state, territorial, District of Columbia, AMA sections, and government service representatives would be responsible for the policy-making, business, fiscal and administrative affairs of the AMA.

On June 4, 1901, the General Convention of the AMA adopted the Committee's plan, and several steps were taken to initiate it:

- A revised constitution and bylaws were designed to "federate" all state medical organizations into the AMA.
- A program was devised to foster and support scientific medicine.
- Another program was established to make the medical profession of the United States a significant power in the social, health, and political matters of this nation.

This is, in essence, the fundamental organization of the AMA today.

To comply with the new constitution

Times haven't changed . . . an editorial from 1947.

Soaring Costs of Hospital Care

That hospitals have been caught in the spiral of inflation everyone should know. This fact was emphasized by hospital representatives at recent hearings in Columbus on proposed new minimum wage scales for women employed in hotels, restaurants, and hospitals, promulgated by the State Department of Industrial Relations.

One witness stated at the hearing that hospital care may be priced completely out of existence if costs of operation continue to soar.

We don't claim to have the answers to this problem. Nevertheless, there are a few things which must be done — quickly — to help alleviate the situation.

Hospital managements should hew to the bone on operating activities. Economies should be made wherever possible. Unnecessary procedures and overhead should be eliminated.

Hospital representatives and physicians should give the public the

facts right on the line. The people should be told what the hospitals are up against. They should be advised that extraordinary demands which many persons are making cost money; add to hospital bills.

Hospital representatives and physicians should discourage requests for extraordinary services and luxuries when ordinary routine services will suffice. Patients should be told that hospital care costs cannot be kept down if each patient requests and receives unnecessary superduper services.

There is a fifty-fifty chance that necessary and good hospital care can be provided at a reasonable cost even in these times if the above suggestions are followed.

All parties concerned must begin to realize that the days of easy money have gone. The time for tightening of belts, economy, and discarding of luxuries has arrived.

and bylaws of the AMA, the Ohio State Medical Society, one year later, adopted its own revised constitution and bylaws which:

- Changed the name of the organization to the Ohio State Medical Association (OSMA).
- Created a House of Delegates, to be composed of elected representatives from each county medical society.
- Divided the county societies into "districts," with each district responsible for electing a councilor to serve on the OSMA Council. The Council would be the executive body which would assume responsibility for OSMA activities in the period between House of Delegate meetings.

Monthly Journal Proposed

Among the unresolved problems of the OSMA that year was the proposal, endorsed by a number of members, that a monthly medical journal be published in lieu of the "Annual Transaction" report, published after each annual convention. A committee, comprised of Council members and members of the OSMA Publication Committee, was appointed to study the advisability of such a move.

The committee's report went first to county medical societies for comment, then, in 1905, it was placed on the agenda of the OSMA House of Delegates. Delegates were polled for their opinion and finally, after prolonged discussions, it was moved: "That future transactions of the OSMA be published in a monthly medical journal, owned by the Association and controlled by its officers (Council)." The proposal was accepted without a dissenting vote.

With its first issue, July 1, 1905, Ohio joined the states of California, Colorado, Kansas, Kentucky, Michigan, Mississippi, Pennsylvania, Wisconsin, and Texas with its own medical journal.

It didn't take long for the *Journal* to begin taking a stand on current issues. That same year, the publication ran an editorial, calling on Congress to reorganize the medical departments of

The Ohio State Medical Journal

S. S. Halderman, M.D.



S. S. Halderman, M.D., Portsmouth, and OSMA President in 1904 was a pronounced advocate for a *State Medical Journal*. In a "Brief History of the *Journal*," published in the May, 1947 issue, Editor Jonathon Forman, M.D., writes of Halderman's speech to the 1904 House of Delegates, pressuring members to "establish, own, and publish a journal exclusively its own."

the Army and Navy, and provide "flag rank" for each of the Surgeon-Generals. The casualties of the Spanish-American War had shown that deaths from disease had far outweighed deaths suffered in battle, due in part the *Journal* said, to "line officers' " control of medical and health affairs.

Other material handled in the *Journal* that first year included treatment of breast cancer, diagnosis and treatment of tuberculosis, statewide registration of births and deaths (legalized in 1908), and the illegal traffic in the sale of cocaine. Discussions of the diagnosis and control of such infectious diseases as smallpox, scarlet fever, typhoid fever, and tuberculosis were also included — diseases seen by few medical students in 1980.

Journal in Trouble

By July, 1915, ten years after the *Journal* had published its first issue, funds for its publication had run out. There was only enough money for one more issue. The House of Delegates considered the matter and decided to rescue the struggling publication by assessing a \$1 per year, per member subscription fee, which succeeded in keeping the *Journal* viable.

The articles and editorials of the revived 1915 *Journal* still involved cancer, its origin and therapy, a nationwide effort made by the American College of Surgeons to stamp out "illegal fee splitting," and the disinfection of public water supplies. Reports carrying news of Ohio physicians in the European theater of World War I also were highly read articles that year.

It was also during that year that the Ohio Hospital Association was formed, and a reversal of a ruling forbidding the sale of malpractice insurance to physicians and surgeons, was announced.

The years following 1915 introduced medicine into explosive scientific and technical advancements. The *Journal* was there, reporting the issues each step of the way.

When the OSMA Committee on Maternal and Neonatal Health was formed to conduct clinical research into reasons for maternal mortality, results

August 1980

An historical footnote

Those interested in medical history may be interested to learn of the existence of the Ohio Academy of Medical History.

The Academy traces its origin to the "Ohio Committee of Medical History and Archives," a little-known committee of the "Ohio Archaeological and Historical Society," which was chaired by OSMA member, and long-time *Journal* editor, Jonathan Forman, M.D. Dr. Forman chaired the committee from 1937 to 1952, and in April of 1952, the Ohio Academy of Medical History was founded.

Academy members share joint membership with the Ohio Historical Society, and constituent membership in the American Association for the History of Medicine.

Annual meetings of the Academy are held at various locations around the state, and agenda items always include the review of several historic medical manuscripts.

Those interested in membership or further information may contact: Office of Secretary, 1100 Euclid Ave., Cleveland, Ohio 44106 — RLM. OSMA

"The years following 1915 introduced medicine into explosive scientific and technical advancements. The *Journal* was there, reporting the issues each step of the way."

were published in the *Journal*.

The *Journal* has collaborated with the division of Continuing Medical Education in presenting seminars and questionnaires which enable the physician to earn "credits" toward relicensure.

The *Ohio State Medical Journal* is the official archives of the House of Delegates, of the Council, its committees and staff, and the Association may be justly proud of its heritage as recorded in the pages of its monthly publication.

In a birthday review such as this, space unfortunately does not permit

the publishing of all the names of the people (both living and deceased), who have worked on the *Journal* throughout its 75-year history. . . the printers, engravers, advertisers, editors, staff, photographers, authors, and readers, without whose help the *Journal* may not have existed. To all of you, please share this birthday with us. And may *The Ohio State Medical Journal* enjoy its 100th anniversary, 25 years from now, as a strong, viable, medical organization publication, worthy of its place in the history of the 21st century. OSMA

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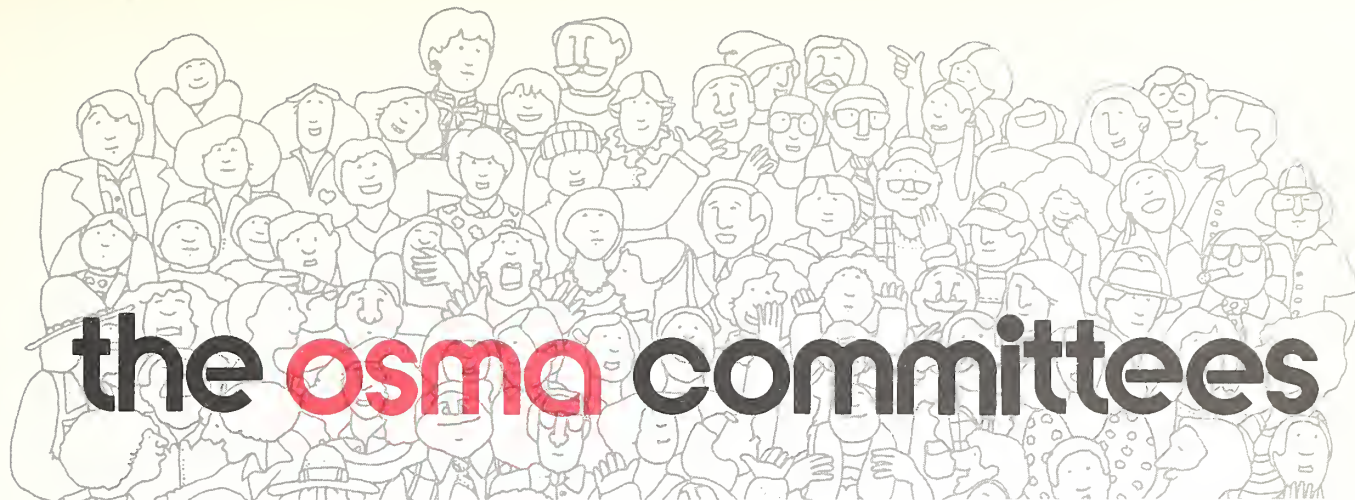
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"Here at the Ohio State Medical Association, standing committees, special committees, various liaison and advisory committees meet to suggest policy and serve to keep the House and Council apprised of issues facing the medical profession."

— From the OSMA Services and Activities handbook.

By the OSMA Staff

With the recent committee appointments made by OSMA President, Robert Thomas, M.D., the *Journal* felt it fitting to not only announce the new committee

members, but to review briefly the purpose of each committee. If you have an idea on an issue which you would like to share, or an opinion you would like to express, you can locate the

appropriate committee by the synopsis and find a list of committee members with whom to get in touch. Now is the time to get involved with your Association, and here is one way to do it.

COMMITTEE LISTINGS

Standing Committees

- Education
- Judicial and Professional Relations
- Membership
- Communications
- Program

Operational Committees

- Auditing and Appropriations
- Cost Effectiveness
- Medical Licensure and Enforcement
- Medical Services
- OSMA-ONA Liaison Committee
- Auxiliary Advisory Committee

- Committee to Review House of Delegates Policy

Special Committees

- AMA-ERF
- Cancer
- Emergency and Disaster Medical Care
- Eye Care
- Federal Legislative Liaison Committee
- Government Medical Care Programs
- Health Manpower
- Laboratory Medicine
- Maternal and Neonatal Health

- Membership Insurance Plans
- Mental Health Impaired Physicians
- Representative to Joint Officers' Committee
- Prisons and Jails
- Professional Liability
- Rehabilitation
- School Health
- Physical Qualification Standards for School Bus Drivers
- Special Education
- Sports Medicine
- State Legislation
- Traffic Safety
- Workers' Compensation

STANDING COMMITTEES

Committee on Education



This committee considers the variety of concerns, issues, or proposals relating to continuing medical education of the membership that may originate from or be referred to it. It formulates appropriate recommendations regarding CME to the OSMA Council and/or other bodies and implements policies/procedures resulting from deliberations of those groups.

Carl E. Spragg, Chairman, New Concord

John H. Ackerman, Columbus

Charles C. Brausch, Cleveland

Paul David Bunn, Youngstown

Evelyn Cover, Columbus

Harvey J. Dworken, Cleveland

James Hickson, Mt. Gilead

Mary Janata, Columbus

Howard S. Madigan, Toledo

Albert May, Marion

Ralph E. Pickett, Newark

Alvin E. Rodin, Dayton

Joseph P. Yut, Canton

Jerry L. Hammon (Liaison - Committee on Scientific Work), West Milton

Committee on Judicial and Professional Relations



This committee investigates at the request of the Council, questions and controversies arising under the Constitution or Bylaws of the OSMA or the Principles of Medical Ethics of the American Medical Association.

Homer A. Anderson, Chairman, Columbus

John A. Devany, Toledo

David Hickson, Mt. Gilead

Thomas W. Morgan, Gallipolis

Robert E. Reiheld, Orrville

Committee on Membership



The purpose of this committee is to develop methods of increasing federation membership and to assure maximum participation of Ohio physicians in the federation: AMA, OSMA, county medical societies, and specialty societies.

Thomas W. Morgan, Chairman, Gallipolis

George Baibak, Toledo

John J. Gaughan, Cleveland

Edward E. Grable, Canton

Stanley J. Lucas, Cincinnati

John H. Taylor, Dayton

William M. Wells, Newark

J. Hutchison Williams, Columbus

Committee on Communications



To develop and plan programs aimed at creating a better public image of the physician; to work for better communications between the physician and the various groups with which he or she must associate, and to provide accurate, timely information on medical and health-related matters to the general public, the media and other organizations and agencies.

Thomas R. Leech, Chairman, Lima

Ronald Berggren, Columbus

A. Robert Davies, Dayton

William Dorner, Jr., Akron

A. Burney Huff, Wooster

Steven Polsley, Urbana

Robert E. Reiheld, Orrville

Leonard Rome, University Heights

Leonard K. Smith, Kenton

James W. Wiggins, Mansfield

Committee on Program



The committee is responsible for making general arrangements for the annual meetings of the Association, including scientific programs in cooperation with scientific sections and specialty groups.

The committee is the accredited CME organization for OSMA, which enables it to designate Category I programs as well as cosponsor such programs.

Jerry L. Hammon, Chairman, West Milton

Robert A. Borden, Fremont

James B. Daley, Fairview Park

John B. McCoy, Elyria

James J. Powers, Columbus

J. Craig Strafford, Gallipolis

John Thinnies, Cincinnati

Richard H. Williamson, Huron

Carl E. Spragg (Liaison - Committee on Education), New Concord

OPERATIONAL COMMITTEES

Ad Hoc Committee on Auditing and Appropriations

This committee is responsible for prescribing the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association and, in general, monitor the fiscal affairs of the Association and report to the members

continued on page 488

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SPONSORED BY: The Ohio State University College of Medicine Center for Continuing Medical Education, and Departments of Pharmacology, Family Practice, Preventive Medicine, School of Nursing and The Ohio Department of Health

OBJECTIVES: This symposium will focus on diagnostic and treatment decisions in the management of primary hypertension. In the morning session, three guest faculty members will discuss the latest information on: the recently completed landmark study, the Hypertension Detection and Follow-Up Program, particularly as it concerns the treatment decisions for patients with mild hypertension; drug interactions in the treatment of hypertensive patients; and the role of protective lipids in hypertension. The afternoon session will focus on two areas of hypertension that warrant special attention: diagnostic decisions in hypertension and treatment decisions in the elderly hypertensive with discussion concerning the latest national task force report on Hypertension in the Elderly. These two topics will feature specialists in the related field, case presentations and discussions with audience participation. Participants may bring their aneroid sphygmomanometers for a calibration check. (This service is included in the cost of registration).

VISITING FACULTY:

- Walter M. Kirkendall, M.D., Professor and Head, Department of Medicine, University of Texas Medical School, Texas Medical Center, Houston, Texas
- Herbert G. Langford, M.D., Professor of Medicine and Physiology; Chief, Endocrinology and Hypertension Division, Department of Medicine, University of Mississippi Medical Center, Jackson, Mississippi
- Simeon Margolis, M.D., Ph.D. Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland
- William A. Pettinger, M.D., Professor of Pharmacology and Internal Medicine; Director of Clinical Pharmacology Division, University of Texas Health Science Center, Dallas, Texas
- Donald G. Vidt, M.D., Head, Clinical Section, Department of Hypertension and Nephrology, Cleveland Clinic, Cleveland, Ohio

THE OHIO STATE UNIVERSITY FACULTY:

- William H. Bay, M.D., Assistant Professor, Department of Medicine
- Joseph R. Bianchine, M.D., Ph.D., Professor and Chairman, Department of Pharmacology; Professor, Department of Medicine, College of Medicine
- David G. Cornwell, Ph.D., Professor and Chairman, Department of Physiological Chemistry; Associate Dean of Research, College of Medicine
- Martin D. Keller, M.D., Professor and Chairman, Department of Preventive Medicine; Assistant Professor, Department of Medicine
- Clifton J. Latiolais, Sc.D., Director of Pharmacy, University Hospitals; Professor, School of Pharmacy
- Albert H. Soloway, Ph.D., Dean, College of Pharmacy
- Mary F. Vaeth, M.D., M.S., Chief, Division of Chronic Diseases, Bureau of Preventive Medicine, Ohio Department of Health

CREDIT: As an organization accredited for continuing medical education, The Ohio State University College of Medicine Center for Continuing Medical Education certifies that this continuing medical education offering meets the criteria for 6 hours in Category 1 of the Physician's Recognition Award of the American Medical Association and the Ohio State Medical Association provided it is used and completed as designed.

Program is accepted for 6 prescribed hours by the American Academy of Family Physicians.
Nurses will receive 0.6 Continuing Education Units.

Pharmacists will receive 0.6 Continuing Education Units.

REGISTRATION: The registration fee of \$30 includes lunch, coffee and all educational materials. Send registration fee on your letterhead to:

Center for Continuing Medical Education, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, telephone 614/422-4985.

the results of the annual audit. The building and properties of the Association are under its supervision.

C. Douglass Ford, Chairman, Toledo
William Dorner, Jr., Akron
S. Baird Pfahl, Jr., Sandusky

Committee on Cost Effectiveness



The Committee on Cost Effectiveness, by House of Delegates action, is committed to the voluntary approach in dealing with health care costs. The committee primarily functions as a catalyst to encourage cost awareness in the practice of medicine. It promotes and encourages those programs that are cost effective and which will not compromise quality medical care.

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John B. McCoy, Elyria
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Task Force on Medical Licensure and Enforcement

The purpose of this committee is to analyze pending legislation relative to the Ohio State Medical Board and current policies and procedures of the Ohio State Medical Board regarding licensing of physicians and enforcement of the medical practice act.

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C. Douglass Ford, Toledo
George T. Harding, Jr., Worthington
James C. McLarnan, Mt. Vernon
Paul S. Metzger, Columbus
Joseph Sudimack, Jr., Warren

John H. Taylor, Dayton
Robert G. Thomas, Elyria
Carl G. Thompson, Jr., Cincinnati

Ad Hoc Committee on Medical Services Review



The purpose of the Medical Services Review Committee is to review and make recommendations to the OSMA Council on requests received from physicians, third-party carriers, and patients relative to disputes which arise out of issues such as the utilization of physician services, medical necessity and appropriateness of medical care.

William Dorner, Jr., Chairman, Akron
Alford C. Diller, Van Wert
A. Burton Payne, Ironton
Joseph P. Yut, Canton

OSMA-ONA Liaison Committee



This committee promotes close cooperation among physicians and nurses in several areas, including continuing education, professional effectiveness, and wellness promotion, legislation and practice policies.

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Walter Haynes, Columbus
H. Judson Reamy, New Philadelphia
William E. Sovik, Poland

Auxiliary Advisory Ad Hoc Committee



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Ad Hoc Committee to Review House of Delegates Policy

This committee reviews past resolutions of the House of Delegates and recommends those resolutions that are pertinent and applicable to present-day environment and conditions and which should continue to be policy of this Association.

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A. Robert Davies, Dayton
Alford C. Diller, Van Wert
Robert S. Heidt, Cincinnati
Richard J. Nowak, Cleveland
H. Judson Reamy, New Philadelphia
Joseph Sudimack, Warren

SPECIAL COMMITTEES

Committee on Cancer

The purpose of the OSMA Committee on Cancer is to stimulate continued advancement in the prevention and treatment of the disease by physicians — in addition to cooperating with other medical and health organizations in a combined effort to attack this disease throughout the entire continuum from preventive education to follow-up care.

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Committee on Emergency and Disaster Medical Care



This committee is involved in improving emergency health care, and stimulating and encouraging the development of improved emergency medical care and transportation in communities throughout the state. In addition, the committee makes every effort to educate physicians and the public in the various aspects of emergency medical systems.

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Gary Crawford, Toledo
Andrew DiBartolomeo, Akron
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Vicki A. Whitacre, Zanesville
James B. Daley, Fairview Park

Committee on Eye Care



The primary purpose of this committee is to evaluate and respond to legislative initiatives regarding vision care. In addition, the committee reviews nonlegislative eye-related matters and acts as OSMA liaison with the Ohio Ophthalmological Society.

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Elson Craig, Columbus
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Barnet R. Sakler, Cincinnati
Lester Stein, Steubenville
Benjamin J. Wherley, Dover
Harry Zink, Wooster

Federal Legislative Liaison Committee



The purpose of the Federal Legislation Liaison Committee is to utilize the "key man" concept in that each member of the committee is a key man who has a personal liaison with the U. S. Senator or Congressman. The key man's responsibility is to convey the position of OSMA on various federal legislation and report back to OSMA his impressions and evaluations of his contact's responses.

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Robert N. Smith, Toledo
William E. Sovik, Poland
Robert G. Thomas, Elyria
Lawrence L. Young, Lima
Robert S. Young, Johnstown

Committee on Government Care Programs



The purpose of the Committee on Government Medical Care programs is to serve the Council and membership in reviewing and studying in depth those matters relating to the

administration and implementation of laws, rules, regulations, and policies governing medical care programs. This task includes making recommendations regarding these various governmental programs and implementing those actions taken by the Council and the House of Delegates.

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Cleveland

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Raymundo de la Pena, Elyria
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Joseph Sudimack, Jr., Warren
Joseph J. Trevino, Piqua
Don P. Van Dyke, Oberlin
Richard J. Wiseley, Toledo
Joseph P. Yut, Canton

Committee on Health Manpower



The purpose of the OSMA Committee on Health Manpower is to study the relationship of allied medical professionals to practicing physicians — and to recommend policies concerning the working relationships which would ultimately benefit the patient.

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Ben Arnoff, Columbus
Robert J. Atwell, Columbus
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Robert D. Gillette, Toledo
Edward G. Kilroy, Cleveland
C. Edward Pichette, Youngstown
Leonard K. Smith, Kenton
Donald G. Vidt, Cleveland
Ross E. Williams, Zanesville

Committee on Laboratory Medicine



The committee monitors legislative and administrative proposals affecting both private and hospital laboratories. The committee serves as the OSMA liaison to the Ohio Society of Pathologists and the College of

American Pathologists. The committee assists the Department of State and Federal Legislation in developing technical data and testimony for legislative and administrative bodies.

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Bruce F. Andreas, Chardon
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Herbert Derman, Columbus
Daniel J. Hanson, Toledo
Robert C. Hastedt, Dover
Victor Hinrichs, Cincinnati
F. LaMont Jennings, Dayton
Richard E. Nensel, Toledo
Robert Schulz, Wooster
Donald Senhauser, Columbus
Robert G. Thomas, Elyria
C. Michael Thorne, Newark
Donald V. Walz, Mt. Vernon

Committee on Maternal and Neonatal Health



The major function of this committee is to study maternal mortality on an annual and continuous study basis with the results leading to improved prenatal care. In addition, the committee studies, reviews, and makes recommendations to the Council in regard to matters relating to maternal and neonatal health.

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Charles V. Bowen, Jr., Akron
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J. Richard Titus, Springfield
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Willys L. Woodward, Toledo

Committee on Membership Insurance Plans



The purpose of this committee is to evaluate and update OSMA membership insurance plans in order to insure availability of the appropriate insurance plans to members.

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Donald Braden, Dover
John A. Devany, Toledo
Raymond Kahn, Dayton
Harry A. Killian, Mentor

Committee on Mental Health



The purpose of the OSMA Committee on Mental Health is to stimulate advancement in the prevention and treatment of mental and emotional diseases, alcoholism, and drug abuse; to cooperate with both private and public mental health agencies in an effort to improve the quality of delivery. This committee also strives to promote the effective practice of medicine by conducting the Impaired Physician's Program which helps physicians suffering from diseases such as alcoholism, drug abuse, and mental illness.

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Representative to Joint Officers' Committee

Robert M. Craig, Dayton

Committee on Prisons and Jails



The purpose of the Committee on Prisons and Jails is, in cooperation with other groups, to study ways and means by which health care in prisons and jails can be improved.

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V. L. Cotterman, Wauseon
A. J. Karson, Medina
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Fredric B. Rothman, Toledo
Brooks H. Sitterley, Marion
John F. Test, Cincinnati

Task Force on Professional Liability

The purpose of the OSMA Task Force on Professional Liability is to evaluate and implement any project, within OSMA's structure, that will in any way improve the professional liability situation.

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George N. Bates, Toledo
Donavin A. Baumgartner, Jr., Cleveland
Stewart B. Dunsker, Cincinnati
John J. Gaughan, Cleveland
A. Burton Payne, Ironton
Robert G. Thomas, Elyria
William M. Wells, Newark

Committee on Rehabilitation



The purpose of the Committee on Rehabilitation is to serve the Council, the departments of the Association and

the membership, in an advisory capacity when expertise regarding rehabilitation is needed.

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Clarence R. Apel, Cambridge
Robert C. Grotz, Cleveland
Daniel M. Murphy, Marion
I. W. Weiden, Sylvania

Committee on School Health



The purpose of the OSMA Committee on School Health is to encourage quality health services and curricula in comprehensive health education in Ohio's elementary and secondary schools.

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Delbert Mason, Oberlin
Richard Moore, Elyria
James M. Orr, Gallipolis
Carl L. Petersilge, Newark
Edward J. Pike, Toledo

Joint Advisory Committee on Sports Medicine

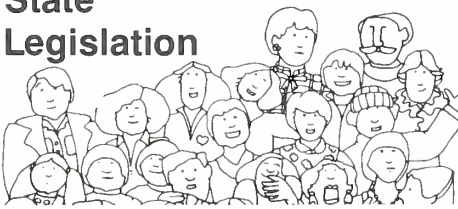


The purpose of the Joint Advisory Committee on Sports Medicine is to promote the health and safety of Ohio's scholastic athletes — through recommendations on the prevention, treatment, and rehabilitation of the athlete — in cooperation with the Ohio High School Athletic Association.

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Gene Wright, Vice Chairman, Lima
Kenneth Akins, Port Clinton
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August 1980

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James Violet, Masillon
Michael J. Vuksta, Youngstown
Frank J. Weinstock, Canton

Committee on State Legislation



The committee reviews legislative proposals if a specific subject matter committee does not have jurisdiction. The committee assists the Department of State Legislation in providing witnesses and/or technical information to the Ohio Legislature.

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Richard D. Ruppert, Toledo
John H. Sanders, Cleveland
Robert E. Schulz, Wooster
William E. Sovik, Poland
Mrs. Rose Vesper, New Richmond
V. William Wagner, Port Clinton
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Committee on AMA-ERF



The purpose of this committee is to promote contributions by members to the American Medical Association Education and Research Foundation in order to eliminate financial barriers for medical students, interns, and residents who are qualified and accepted by approved training institutions.

Philip B. Hardymon, Chairman,
Columbus

Joint Advisory Committee on Special Education

This committee assists the Division of Special Education, Ohio Department of Education, with establishing, reviewing, and amending when necessary, medical aspects of special education standards in the areas of hearing handicapped, visually handicapped, orthopedically handicapped, multihandicapped, severe behavior handicapped, developmentally handicapped, and specific learning disabled children.

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Committee on Traffic Safety



The purpose of the OSMA Committee on Traffic Safety is to study the medical aspects of accident prevention — and to make recommendations as to how to more effectively prevent accidents.

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Frank J. Weinstock, Canton

Advisory Committee on Physical Standards for School Bus Drivers

This committee assists the Pupil Transportation Division, Ohio Department of Education, with establishing, reviewing, and when necessary, criteria for physical qualifications for amending Ohio's school bus drivers.

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Ron Agresta, Steubenville
James Burkholder, Canton
Robert M. Hess, Columbus
Lawrence McCormack, Sandusky
Paul W. McFadden, Dover
C. Nicholas Walz, Toledo

Committee on Workers' Compensation



The purpose of this committee is to keep abreast of legislation, regulations and the implementation of the Workers' Compensation program in Ohio and to make recommendations for improvement in the program.

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Herman I. Abromowitz, Dayton
George Franck, Cleveland
Lawrence T. Hadbavny, Cleveland
Sidney I. Lerner, Cincinnati
J. Richard Nolan, Astabula
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A Different Welcome

By Karen S. Edwards

"I looked at those (Cuban) refugees, many who were the same age as me when I came over, and felt sad that they have received such a different welcome. But what else could this country do?"
— Carlos Andarsio, M.D.,
Springfield, Ohio.

It was like stumbling onto a M.A.S.H. unit.

Row upon row of tents made alleyways out of a dusty, open field and everywhere medical personnel in uniform were trying hard to be three places at once. The laboratory, pharmacy, and examination rooms were makeshift at best, and equipment and medication were adequate, no more.

Among this sense of ordered chaos worked the physicians, one or two at most, on a shift that went from 7 a.m. to 7 p.m. or 7 p.m. to 7 a.m., seven days a week. The work never seemed to stop, and the patients never seemed to stop coming through the doors.

It was a scene such as this in which Carlos Andarsio, M.D., voluntarily placed himself this spring.

A proctologist, practicing in Springfield, Ohio, Dr. Andarsio, still holds a keen interest in the affairs of his native Cuba. So it was only natural that when Castro first launched his "Freedom Flotilla," comprised of hundreds of boatloads of Cuban refugees bound for the United States, Dr. Andarsio followed the headlines closely.



Carlos Andarsio, M.D.

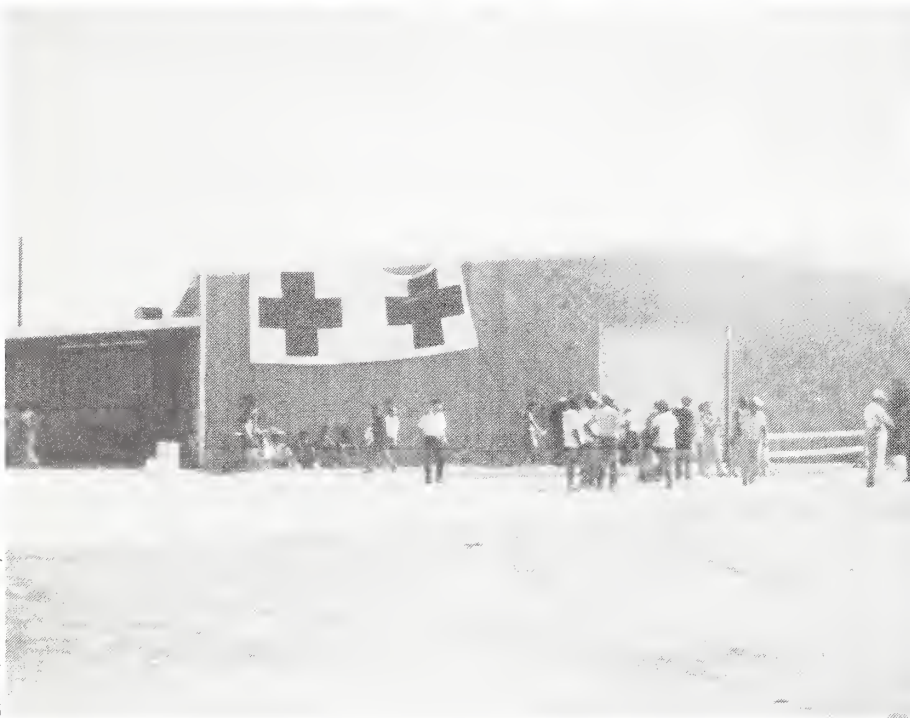
The Cuban refugee camp outside Eglin Air Force Base, Fort Walton Beach, Florida.

Carlos Andarsio, M.D.



The open-air camp laundry.

Carlos Andarsio, M.D.



The camp hospital.

Carlos Andarsio, M.D.



Refugees line up for meals, served just twice a day.

"It's not easy for an immigrant to come to this country," Dr. Andarsio said. "An alien must have either a job or a family waiting in order to be immediately received into the United States. If he or she has neither, there is a lengthy, tedious admitting process to go through."

Headlines told him how camps close to military installations were set up in Florida and other parts of the South to handle the tremendous influx of refugees who would have to be processed. But headlines did not tell him what he knew would be true.

"I wanted to help. I knew there would be a language problem at those camps, and since I know the language, I knew I could prove helpful as both a physician and interpreter."

So, Dr. Andarsio contacted U.S. Rep. Clarence J. Brown's office as well as Air Force officials to volunteer his services at one of the Cuban refugee camps. Arrangements soon were made for him to spend six days at Eglin Air Force Base at Fort Walton Beach, Florida, making him one of the first, if not the first, civilian physician to serve in such a voluntary capacity.

People In Need

In a letter sent to Dr. Andarsio after his visit to the camp, Lt. Col. Robert P. Griffin, Commander of the USAF 363 TAC Hospital where Dr. Andarsio served, said:

"It is not often that one will take a week away from a busy practice, travel to another city, and stay in a motel, all at his own expense, to provide a service to people in need."

The words seem to echo more strongly in light of certain communiques that were being sent by a Florida-based society of Cuban physicians in exile, at about the same time Dr. Andarsio was volunteering his services. The communiques urged the society's members to volunteer their services at the refugee camps, but they met with little enthusiastic response. In fact, a sort of *aisez-faire*, "let government do it" attitude seemed to prevail.

Certainly, at Eglin Air Force Base, Dr. Andarsio was the only civilian physician present, and his services were put to use almost the minute he landed.

"I thought I would be working at the base hospital," Dr. Andarsio admits, then tells how he was taken to a

The Ohio State Medical Journal

fairgrounds area, outside the base.

"The camp was makeshift and rather primitive," Dr. Andarsio said. Tents housing 30 cots had been set up as sleeping quarters for the refugees. There was a laundry, toilet and shower facilities, and the hospital which had been set up in the camp's only air-conditioned building.

Here, required physical screenings were being done by the federal government's Public Health Service on all of the 9,000 refugees assembled at the camp. An emergency room, that was in essence a primary care facility, occupied one part of the building, and it was here that Dr. Andarsio was put to work.

"We saw an average of 500 people a day. Most of the patients were treated for asthma and upper respiratory infection and quite a few for diabetes. Diarrhea proved to be no problem at all."

Critically ill patients, such as the one with myocardial infarction, were moved to the base hospital at Eglin.

Carlos Andarsio, M.D.



Examination rooms were makeshift at best.

That's not especially surprising unless you realize that up until this time, Castro permitted few people between these ages to leave the country. Over

those who came over with us," Dr. Andarsio was told by one of the older refugees at the camp.

"I think President Carter did what anyone would have done in allowing the refugees to enter this country," Dr. Andarsio reflected later. "After all, this country is based on certain freedoms and it still offers an opportunity, a hope to the oppressed. However, I feel that if certain refugees are proven undesirables, then they should receive the same treatment as any other undesirable trying to enter this country. They should be sent back."

"I would estimate that the United States will have trouble relocating one third of the refugees . . ."

Dr. Andarsio agrees that it's not difficult to understand the high number of patients being seen at the hospital. After all, the refugees had time on their hands, free medical service at their disposal, and a chance to beat Florida's heat and humidity in air-conditioned surroundings.

What is not so easily explained, however, is the high rate of psychiatric disorders which accounted for 16 percent of all hospital admissions within the first two weeks of the camp, placing the illness an astonishing third behind a catch-all "others" category and the aforementioned asthma.

Does the high figure reflect the kind of individuals who left Castro's society?

50, yes, but not his younger, productive citizens.

"I am Cuban, and I am glad to be here, but I am ashamed of some of

Relocation Problems

"I would estimate that the United States will have trouble relocating one third of the refugees at that camp," Dr. Andarsio said.

Backing up that statement is yet another curious figure. Seventy percent of the patients seen at the hospital were between the ages of 21 and 40.

Carlos Andarsio, M.D.



Two Cuban physicians were among the refugees who came to the U.S. They helped where they could in the hospital.

It is with such mixed emotions that Dr. Andarsio regards the plight of the Cuban refugees.

"There are so many grounds on which to consider the situation," he said. "Politically and religiously, we welcome them, but socially and economically. . ." he shakes his head as he lets the sentence drift.

"A refugee told me that Castro is taking the minds of the people. There's no food, no medicine, no freedom. People will do anything to leave Cuba."

Dr. Andarsio left Cuba before Castro gained control — but he stresses that there have been only two short spans in his lifetime when Cuba has been free of a dictatorship.

"When I left, there was still a semiprivate practice of medicine. Today, it's strictly socialized."

Telltale Signs

The signs of socialization were becoming more and more apparent when he left, as government-controlled agencies became the prominent fixture in Cuba's health care, entirely consuming the free enterprise, private practice system.

Does he see any telltale signs of the United States facing such a future as government regulations on health care seem to increase almost daily?

"Yes, I see signs of a socialized system developing," he says, but adds that physician fees will probably feel the brunt of government control the quickest.

"The people soon will be unable to pay for the kind of health care we can provide, and then government will step in with a fee schedule for physicians."

Among the refugees in the camp were two Cuban physicians who spoke with Dr. Andarsio about practicing medicine in Cuba.

"Apparently, it's almost impossible to practice there. You can't get equipment or medications," Dr. Andarsio recalls. "The people receive medical care when they can get it." The present makeshift facilities at the camp, it seems, are not altogether different and may even be better than what the refugees have left behind.

Dr. Andarsio has fond memories of his homeland. A photograph on a credenza in his office shows him in



Carlos Andarsio, M.D.

younger days, sporting a baseball uniform and posing with the rest of the Cuban baseball team with which he played for two years. It was through a classmate of his that Dr. Andarsio finally came to the United States. The friend came to work at Mt. Carmel Hospital in Columbus and Dr. Andarsio wrote and asked him if there were any internships open. In 1957, with his wife, daughter, and a letter from Mt. Carmel attesting to the fact that a job was waiting for him, Dr. Andarsio arrived in the "land of

promise," — young, eager, and excited.

"I looked at those refugees, many who were the same age as me when I came over, and felt sad that they have received such a different welcome. But what else could this country do?"

He shakes his head, "There's no easy answer."

"I'm glad that I went, that I had the experience. But I wouldn't want to repeat it for a long, long time. It's just too emotionally draining for me." **OSMA**

Report on the Examination of Financial Statements for the Years Ended December 31, 1979 and 1978

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1979 and 1978 and the related statements of operations and net worth and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our report dated March 9, 1979, our opinion on the 1978 financial statements was qualified due to the uncertainty of the recoverability of a receivable from a nonprofit corporation. As explained in Note 3, the receivable has been charged to opera-

tions in the current year as required by generally accepted accounting principles. Accordingly, our present opinion on the 1978 financial statements, as presented herein is different from that expressed in our previous report.

In our opinion, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1979 and 1978 and the results of its operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Columbus, Ohio
March 10, 1980

Coopers & Lybrand

OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1979 and 1978

ASSETS		1979	1978
Current assets:			
Cash and cash equivalents		\$1,206,341	\$568,177
Accounts receivable		50,412	37,835
Investment in Ohio Medical Indemnity, Inc. at cost (Note 6)			56,000
Prepaid expenses		22,041	22,933
Total current assets		<u>1,278,794</u>	<u>684,945</u>
Other assets:			
Due from Medical Advances Institute (Note 3)			75,217
Investments:			
General Trust Fund, at cost which approximates market		49,012	48,680
Physicians Insurance Company of Ohio (PICO), at cost (Notes 8 and 9)		100,000	100,000
Prepaid conversion costs on computer installation, net of \$12,146 amortization in 1979 (Note 1)		48,584	38,777
		<u>197,596</u>	<u>262,674</u>
Property and equipment, at cost (Notes 1 and 2):			
Building		526,091	548,896
Data processing equipment		111,714	81,998
Furniture, fixtures and equipment		90,362	91,404
		<u>728,167</u>	<u>722,298</u>
Less accumulated depreciation		(136,965)	(105,148)
		<u>591,202</u>	<u>617,150</u>
Land		289,113	249,787
		<u>880,315</u>	<u>866,937</u>
		<u>\$2,356,705</u>	<u>\$1,814,556</u>

LIABILITIES AND NET WORTH

	1979	1978
Current liabilities:		
Accounts payable	\$ 92,027	\$ 98,681
Current portion, term debt (Note 2)	21,549	19,897
Other current liabilities	457,285	242,605
Total current liabilities	<u>570,861</u>	<u>361,183</u>
Term debt (Note 2)	<u>157,816</u>	<u>179,365</u>
Deferred income:		
Annual membership dues (Note 1)	244,580	132,708
Life membership dues (Note 1)	42,300	44,400
Other	3,455	7,413
	<u>290,335</u>	<u>184,521</u>
Net worth (Notes 7 and 10)	<u>1,337,693</u>	<u>1,089,487</u>
	<u>\$2,356,705</u>	<u>\$1,814,556</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF OPERATIONS AND NET WORTH for the years ended December 31, 1979 and 1978

	1979	1978
Income:		
Membership dues (Note 1)	\$1,785,093	\$1,296,595
Exhibit fees	22,780	18,900
Annual meeting	32,033	24,450
Fees for collection of AMA dues	18,158	14,050
CME accreditation and courses	2,005	3,751
Ohio State Medical Journal (Note 7)	136,874	121,480
Interest on savings accounts and certificates of deposit	91,871	48,387
General trust income (loss)	(1,168)	8,053
Rental income	20,456	12,814
Other	7,977	4,811
	<u>2,116,079</u>	<u>1,553,291</u>
Departmental operating expenses:		
Administration	358,891	308,012
Convention coordinator and CME	225,788	201,467
Health education	80,725	65,961
Field service	66,099	60,297
Financial and membership	221,189	194,484
Government medical care (Note 3)	200,452	74,641
Ohio State Medical Journal (Note 7)	252,477	219,741
Organizational services	142,688	105,525
Federal Legislation and Public Policy	56,138	93,699
State legislation	140,844	106,587
Communications	113,882	91,850
Malpractice Research Fund and Allocated Rental Expenses	8,700	16,084
	<u>1,867,873</u>	<u>1,538,348</u>
Net income from operations	<u>248,206</u>	<u>14,943</u>
Net worth, beginning of year	<u>1,089,487</u>	<u>1,074,544</u>
Net worth, end of year	<u>\$1,337,693</u>	<u>\$1,089,487</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FINANCIAL POSITION
for the years ended December 31, 1979 and 1978

	1979	1978
Source of funds:		
From operations:		
Net income	\$248,206	\$14,943
Depreciation and amortization not requiring working capital	54,108	31,759
Increase in deferred income (net of \$2,100 amortization of life memberships)	105,814	72,281
Additional long-term indebtedness		72,000
Write-off of accounts receivable from MAI	75,217	
	<u>483,345</u>	<u>190,983</u>
Application of funds:		
Acquisition of property and equipment, net	55,340	170,068
Increase in General Trust Fund	332	5,082
Repayment of term debt, net of conversions to current	21,549	21,525
Conversion costs of computer installation	21,953	38,777
	<u>99,174</u>	<u>235,452</u>
Increase (decrease) in working capital	<u>\$384,171</u>	<u>\$(44,469)</u>
Changes in the components of working capital:		
Increase (decrease) in current assets:		
Cash	\$638,164	\$2,547
Accounts receivable	12,577	13,648
Investment, Ohio Medical Indemnity, Inc.	(56,000)	
Prepaid expense and unamortized costs	(892)	3,217
	<u>593,849</u>	<u>19,412</u>
Increase (decrease) in current liabilities:		
Accounts payable	(6,654)	(46,928)
Current portion, term debt	1,652	1,879
Accrued interest		(979)
Other current liabilities	214,680	109,909
	<u>209,678</u>	<u>63,881</u>
Increase (decrease) in working capital	<u>\$384,171</u>	<u>\$(44,469)</u>

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:

Depreciation and amortization are recognized on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:

Buildings	40 years
Data processing equipment	5 years
Furniture, fixtures and equipment	10 years
Prepaid conversion costs on computer installation	5 years

Depreciation and amortization charged to operations amounted to \$54,108 in 1979 and \$31,759 in 1978.

b. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

2. Term Debt:

Term debt at December 31, 1979 consisted of the following:

8% Mortgage loan payable in monthly installments of \$2,427, including interest, collateralized by land and building, and due July 1, 1984

\$107,679

8% Mortgage loan payable in monthly installments of \$500, including interest computed semi-annually, collateralized by land and building. OSMA has the right of prepayment of principal not to exceed \$10,000 per annum, noncumulative, for the first five years. After five years, OSMA has an unlimited right of prepayment

71,686

179,365

Less current portion

21,549

\$157,816

3. Due from Medical Advances Institute:

In prior years, the Association advanced \$75,217, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio corporation not for profit, to support this organization's development of a computerized peer review system. The recovery of funds advanced to MAI was generally dependent upon the successful marketing of the system. MAI has ceased operations and plans to terminate all operations by April 1980 without any sale of the computerized peer review system. As a result, the Association has charged to the Government Medical Care Department in 1979, the expense of writing off the receivable from MAI.

4. Pension Plan:

The Association has a salaried employee's pension plan covering substantially all of its employees. The pension costs (including an allowance for annual life insurance premiums) for the year 1979 was \$79,821 and for 1978 was \$85,681. At December 31, 1979 and 1978, the actuarially computed value of vested benefits exceed plan assets by \$134,261 and \$114,598, respectively.

The Association has completed its amendment of the pension plan in compliance with the Employee Retirement Income Security Act of 1974 (ERISA), and the pension costs for 1979 and 1978 reflect such amendment changes.

5. Leases:

The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1979:

	1980	1981	1982
Equipment and other	\$10,173	\$1,808	
Automobiles	11,281	2,162	\$1,261
	<u>\$21,454</u>	<u>\$3,970</u>	<u>\$1,261</u>

Rental expense under these and similar leases aggregated \$42,464 during 1979 and \$39,524 during 1978.

6. Investment — Ohio Medical Indemnity, Inc.:

At December 31, 1978, the Association owned 100% of the outstanding common stock, 8,000 shares, of Ohio Medical Indemnity, Inc. purchased at a cost of \$56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) was prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company.

The Association was also the defendant in a civil action brought by the Attorney General of the State of Ohio

The Ohio State Medical Journal

which alleged violations of federal and state antitrust laws resulting from monopolistic practices; and sought treble damages and divestiture of ownership in Ohio Medical Indemnity, Inc., the Association's wholly-owned subsidiary.

On March 22, 1979, a settlement agreement was executed by the State of Ohio, Ohio State Medical Association and Ohio Medical Indemnity, providing for the divestiture of ownership of Ohio Medical Indemnity by Ohio State Medical Association. The settlement agreement provided that the treble damage claims by the State of Ohio against the Association be dismissed with prejudice and without any payment by the Association, and, that the original investment of \$56,000 be returned to the Association in redemption of all outstanding shares of Ohio Medical Indemnity, which was to be converted to a mutual insurance company. The agreement further provided that Ohio Medical Indemnity is to make a charitable grant in the name of the Ohio State Medical Association and in the amount of \$1,000,000 to further geriatric medicine programs of Ohio's medical schools. During 1979, Ohio Medical Indemnity has been converted to a mutual insurance company and returned to the Association its original investment.

7. Ohio State Medical Journal:

The income and expenses applicable to the operations of "Ohio State Medical Journal" are as follows:

	1979	1978
Income:		
Advertising (net of commissions of \$28,304 in 1979 and \$28,326 in 1978 and cash discounts of \$1,830 in 1979 and \$1,163 in 1978)	\$118,998	\$112,315
Subscriptions received from nonmembers	5,946	3,803
Other	11,930	5,362
Membership subscriptions, allocated at \$5.90 for 1979 and \$6.95 for 1978, per dues-paying member (included in membership dues income on the Statement of Operations and Net Worth)	61,307	73,705
	<u>198,181</u>	<u>195,185</u>
Expenses:		
Salaries, pension costs, payroll taxes and other employee benefits	81,385	75,236

Printing, postage, stationery, supplies, illustrations, engravings, and consulting services

148,472

128,997

Building expenses, depreciation and other

22,620

15,508

252,477

219,741

Excess of expenses over income, Ohio State Medical Journal

\$54,296

\$24,556

8. Investment — Physicians Insurance Company of Ohio:

The Association owns 100% of the Class B. common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each Class of stock has equal rights on a per share basis to participate in dividends and other types of distributions, whether from earnings or in the nature of dividends. The Association received \$2,500 dividend income in 1979 which is included in other income in the accompanying statement of operations and net worth. Each Class A share is entitled to one vote and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the outstanding Class B shares (5,000 shares), the Association is entitled to 500,000 votes. At December 31, 1979, the Class A shareholders owned 425,901 shares of Class A stock. Accordingly, at December 31, 1979, the Association was entitled to exercise 54.0% of the voting power of PICO. When the total authorized Class A shares (2,000,000) and Class B shares (16,667) have been sold, the Class A shareholders will have 55% of the voting control over PICO.

Physicians Insurance Company of Ohio had a total stockholders' equity of \$10,392,713 at December 31, 1979 and \$9,119,606 at December 31, 1978. The Association's equity in PICO totaled \$120,592 at December 31, 1979 and \$108,495 at December 31, 1978.

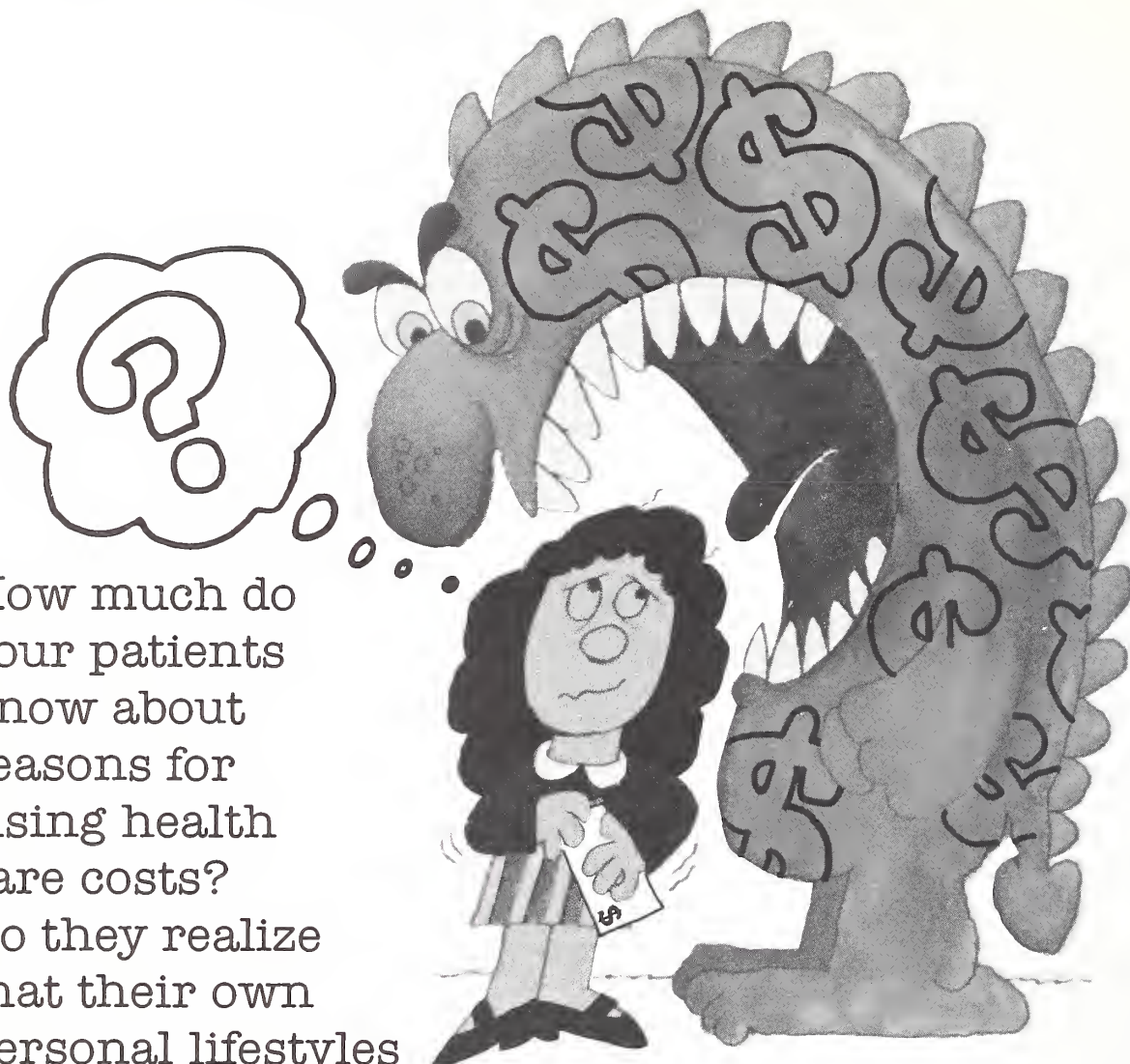
9. Insurance Holding Company System:

The insurance holding company system presently consists of two affiliated persons, the Ohio State Medical Association (OSMA) and Physicians Insurance Company of Ohio (PICO).

OSMA controls PICO by virtue of its ownership of 100 shares of Class B common stock of PICO, comprising 100% of such outstanding shares of stock (see Note 8).

10. Exemption — Federal Taxes on Income:

The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.



Cartoon Courtesy of ASIM

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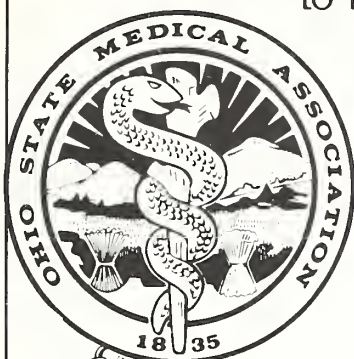
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CONTINUING EDUCATION PROGRAMS

SELECTED TOPICS IN TRAUMA MANAGEMENT: September 24; Daytonian Hotel, Third & Ludlow Street, Dayton; sponsor: Wright State University School of Medicine; 8 credit hours; fee: \$65, Wright State faculty \$50; contact: Ms. Arlene Polster, Wright State University, P. O. Box 927, Dayton 45401, phone: 513/372-7140.

FIRST ANNUAL REFRESHER, UPDATE AND BOARD PREP IN PSYCHIATRY: September 27-28; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine; 16 credit hours; fee: \$125 Wright State faculty, \$150 others; contact: Ms. Arlene Polster, Wright State University, P. O. Box 927, Dayton 45401, phone: 513/372-7140.

7TH ANNUAL "PEDIATRICS FOR THE PRACTICING PHYSICIAN" SYMPOSIUM: September 26-27; Holiday Inn, Perrysburg; sponsor: Toledo Pediatric Society; cosponsor: Medical College of Ohio at Toledo; 12 credit hours; fee: \$125, no fee to residents; contact: James Lustig, M.D., St. Vincent Hospital and Medical Center, 2213 Cherry Street, Toledo 43608.

HOW TO IDENTIFY THE ALCOHOLIC IN YOUR PRACTICE: October 8; Sheraton Dayton Downtown; sponsors: Wright State University School of Medicine and Community Hospital of Springfield and Clark County; 7 credit hours; fee: \$65, \$50 Wright State faculty; contact: Ms. Arlene Polster, Wright State University, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

DERMATOPATHOLOGY SELF-ASSESSMENT WORKSHOP: October 11; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland; 6 credit hours; fee: \$75, \$40 for students or physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

SYMPOSIUM ON RENAL AND UROLOGIC DISEASE IN CHILDREN: October 15; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland; 4 credit hours; fee: \$25; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

October

September

PHYSICAL AND PSYCHOLOGICAL ASPECTS OF SHORT STATURE: September 10; Children's Medical Center, Dayton; sponsor: Wright State University School of Medicine; 8 credit hours; \$45, \$35 Wright State faculty; contact: Ms. Arlene Polster, Wright State University, P. O. Box 927, Dayton 45401, phone: 513/372-7140.

MEDICINE UPDATE 1980: September 24; Holiday Inn, Interstate 77 and Rockside Road, Independence; sponsor: Cleveland Clinic Educational Foundation and Deaconess Hospital of Cleveland; 6 credit hours; no fee; contact: Felino V. Barnes, M.D., Deaconess Hospital, 4229 Pearl Road, Cleveland 44109.

1980-81 CORE CONTENT REVIEW OF FAMILY MEDICINE: October 1980-May 1981 monthly; Correspondence Course; sponsor: Ohio Academy of Family Physicians; 32 credit hours; fee: \$65 AAFP Members, \$85 nonmembers; contact: Mrs. Florence I. Landis, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

WHAT'S NEW IN RHEUMATIC DISEASE: October 8; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland; 6 credit hours; fee: \$60, \$30 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

INTRODUCTION TO BRAIN STEM, AUDITORY EVOKED POTENTIAL TESTING: October 17-18; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland; 12 credit hours; fee: \$200, \$100 for students or physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

CONFERENCE ON SPECTROSCOPIC METHODS FOR BIOMEDICAL RESEARCH: October 20-21; Battelle Columbus Laboratories, 505 King Avenue; sponsor: Battelle's Columbus Laboratories and Bioengineering Center of the University of Washington. 14 hours Category 2; contact: Mrs. Karen L. Waite, Battelle's Columbus Laboratories, 505 King Avenue, Columbus 43201, phone: 614/424-4179.

**UPDATE ON STROKE AND
CEREBRAL VASCULAR DISEASE:**

October 22; Bunts Auditorium,
Cleveland Clinic, 9500 Euclid Ave.,
Cleveland; 6 credit hours; fee: \$50, \$25
for students or physicians-in-training;
contact: Director of Continuing Medical
Education, Cleveland Educational
Foundation, 9500 Euclid Ave.,
Cleveland 44106, phone: 216/444-5696.

A SYMPOSIUM ON ARTHRITIS:

October 22; Imperial House South,
West Carrollton; sponsor: Wright State
University School of Medicine;
cosponsor: Lederle Labs; 7 credit
hours; no fee; contact Ms. Arlene
Polster, Wright State University, P. O.
Box 927, Dayton 45401, phone:
513/372-7140.

**ADVANCES IN PEDIATRIC
NEUROLOGY AND**

NEUROSURGERY: October 29; Bunts
Auditorium, Cleveland Clinic, 9500
Euclid Ave., Cleveland; 6 credit hours;
fee: \$50; contact: Director of
Continuing Medical Education,
Cleveland Clinic Educational
Foundation, 9500 Euclid Ave.,
Cleveland 44106, phone: 216/444-5696.

TECHNIQUES IN ORTHOPAEDIC

SURGERY: October 30-31; Bunts
Auditorium, Cleveland Clinic, 9500
Euclid Ave., Cleveland; 12 credit hours;
fee: \$170; contact: Director of
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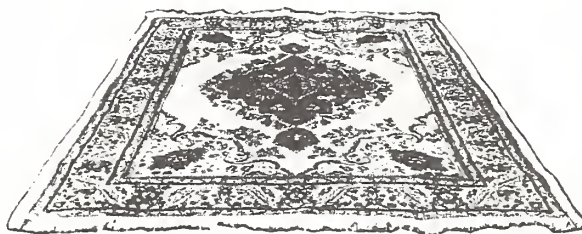
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Richard Bellas, Dayton
Gerald Dysert, Troy

MONTGOMERY (Dayton unless noted)

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FRED W. DIXON, M.D.,
Englewood, Florida; University of
Louisville School of Medicine, 1915;
age 87; died April 4; member OSMA
and AMA.

WALTER FELSON, M.D.,
Greenfield; University of Cincinnati
College of Medicine, 1935; age 71; died
June 11; member OSMA and AMA.

JOHN E. GALLAGHER, M.D.,
Rossford; Washington University
School of Medicine, St. Louis, 1940; age
66; died June 10; member OSMA and
AMA.

CHARLES S. GREENE, M.D.,
Canton; University of Cincinnati
College of Medicine, 1928; age 75; died
June; member OSMA and AMA.

JOHN R. HIGERD, M.D.,
Ashtabula; Hahnemann Medical
College and Hospital, Philadelphia,
1935; age 71; died June 17; member
OSMA and AMA.

EDGAR S. LOTSPEICH, M.D.,
Cincinnati; University of Louisville
School of Medicine, 1939; age 64; 1978;
member OSMA and AMA.

GEORGE MARDERWALD, M.D.,
Alliance; Medical College of Ohio,
Toledo, 1974; age 30; died June 16;
member OSMA.

HAROLD FRANK MILLS, M.D.,
Mansfield; Ohio State University
College of Medicine, 1932; age 72; died
May 15; member OSMA and AMA.

LEWAARON H. MOYER, M.D., St.
Petersburg, Florida; University of
Pittsburgh School of Medicine, 1929;
age 76; died January; member OSMA
and AMA.

HOWARD E. POSSNER, M.D.,
Canton; Jefferson Medical College of
Thomas Jefferson University,
Philadelphia, 1941; age 65; died
February 19, 1979; member OSMA and
AMA.

RUDOLPH SCHORK, M.D.,
Newton Highlands, Massachusetts, ;
John Hopkins University School of
Medicine Baltimore, 1929; age 77; died
June 4; member OSMA and AMA.

NICHOLAS M. STEINER, M.D.,
Scottsdale, Arizona; University of
Medicine of Berlin, Prussia, Germany,
1926; age 81; died February 29; member
OSMA and AMA.

EDGAR A. STONE, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1948;
age 66; died June 18; member OSMA
and AMA.

RICHARD WENRICK, M.D.,
Hillsboro; University of Cincinnati
College of Medicine, 1934; age 71; died
December 28, 1979; member OSMA
and AMA. *OSMA*

JAMES H. BAHRENBURG, M.D.,
Canton; Case Western Reserve
University School of Medicine, 1931;
age 75; died May; member OSMA and
AMA.

BELA J. BALLO, M.D., Tiffin;
University of Budapest School of
Medicine, Hungary, 1923; age 82; died
May 28; member OSMA.

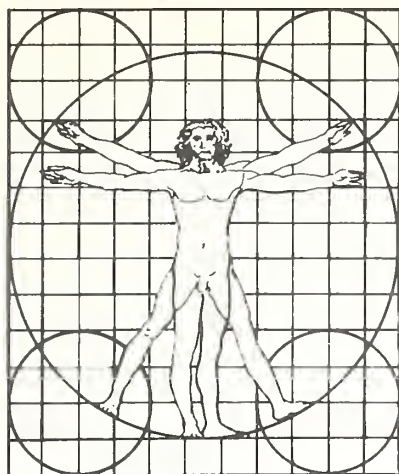
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Mansfield; Eclectic Medical College,
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CLINICAL & SCIENTIFIC

High Density Lipoprotein (HDL): A Protective Lipoprotein

James M. Falko, M.D.

High-density lipoproteins (HDL) are a complex group of lipoproteins that play an important role in "reverse" lipid transport. During the past few years there has been a ferment of rediscovery of the independent relation of HDL to coronary heart disease. Epidemiologic data indicate that HDL-cholesterol is a powerful strong negative risk factor in the development of atherosclerosis. My purpose is to review briefly the factors influencing HDL as a protective lipoprotein.

DURING THE PAST FEW YEARS there has been considerable debate regarding measuring lipoproteins compared to measuring total lipids alone. However, recent epidemiologic data indicate that individual lipoproteins, rather than total lipids, are better predictors of atherosclerosis than levels of total lipids alone.¹ Thus, low density lipoprotein (LDL) is a powerful positive risk factor and high density lipoprotein (HDL) is an equally strong, though negative, risk factor in the development of atherosclerosis. My intention is to update the evidence that HDL has emerged as a protective lipoprotein and review the factors that modulate HDL levels.

Evidence for HDL as a Protective Lipoprotein

Over 25 years ago an inverse relationship between HDL and atherosclerosis was suggested.² But it was not until 1975 that Miller renewed interest in HDL.³ He noted that patients who suffered a myocardial infarction had low levels of HDL, compared to age and sex-matched controls who had similar levels of total lipids and the other lipoproteins including LDL. Since then, large epi-

demiologic studies have confirmed this finding.⁴ Furthermore, subjects from families with high HDL levels have a low incidence of coronary heart disease and increased longevity.⁵

Similarly, individuals who engage in sustained physical activity have a low incidence of atherosclerosis and high levels of HDL.⁶

Pathophysiology of HDL

HDL is secreted by the liver and intestine. Nascent HDL is a disc-like particle composed of primarily phospholipid and protein. HDL in plasma appears also by the catabolism of triglyceride-rich lipoproteins (very low density lipoproteins ((VLDL)) and chylomicrons). The triglyceride-rich lipoproteins are metabolized by an enzyme called lipoprotein lipase to smaller particles called "remnants." During this conversion, materials that are disc-like in structure are pinched off the surfaces and the HDL disc-like particle picks up cholesterol. The enzyme lecithin cholesterol acyl transferase (LCAT) then esterifies cholesterol to its ester and an HDL spherical particle results. Therefore, one pathway is the liver and/or intestine providing HDL and another involves the flux of VLDL or chylomicrons originating from the catabolism of these particles through lipoprotein lipase.⁶ This implies that HDL rises in situations which result in increased flux of triglyceride-rich particles (VLDL or chylomicrons) when associated with normal or increased levels of lipoprotein lipase. Conversely, low levels of HDL are associated with decreased flux of VLDL and/or decreased levels of lipoprotein lipase.⁶

The molecular basis of HDL's protective role has been shown experimentally. HDL-cholesterol (HDL-C) is negatively correlated with the total body cholesterol pool and arterial cell cholesterol content.⁶ Furthermore, HDL can remove cholesterol from arterial smooth muscle cells and reduce the uptake of LDL by smooth muscle cells. Thus, HDL can serve as a "reverse transport"

Dr. Falko, Columbus, Assistant Professor of Medicine, Division of Endocrinology and Metabolism, The Ohio State University College of Medicine.

Reprint requests to The Ohio State University College of Medicine, Division of Endocrinology and Metabolism, 410 W. Tenth Ave., Rm N-1111, Columbus, OH 43210 (Dr. Falko).

Submitted November 7, 1979.

lipoprotein by removing cholesterol from the peripheral tissues carrying cholesterol back to the liver for excretion.⁶

Quantitation of HDL

Fractionation of HDL has been done through the use of a preparative or analytical ultracentrifuge with cholesterol levels determined on the resultant fractions. This is time consuming and the equipment is not readily available to most clinical laboratories. A common way to quantitate HDL is by measuring its cholesterol content (HDL-C). This can be accomplished by precipitating the non-HDL lipoproteins with polyanions and divalent cations. This method is reasonably simple and can yield clinically important information. However, occasional preliminary ultracentrifugation often is necessary to remove excessive chylomicrons and/or VLDL. By using this method, LDL-cholesterol (LDL-C) can be quantitated as well by the following formula: $\text{LDL-C} = \frac{\text{total cholesterol} - (\text{Total TG} + \text{HDL-C})}{5}$. This formula is

valid if the total triglyceride concentration is less than 400 mg/dl.⁷

Recently, the method ordinarily used to measure HDL-C concentrations in commercial clinical laboratories is by separating lipoproteins by electrophoresis on agarose or cellulose acetate strips and incubating with an enzymatic cholesterol reagent. HDL-C computations then are made by multiplying the relative peak area densitometrically of HDL by the enzymatically determined total cholesterol. This method usually is valid even when significant hypertriglyceridemia is present. Of note is that HDL-C concentrations can be done on nonfasting plasma samples. Clinicians should be provided with "norms" that are *standardized* by individual clinical laboratories or by the Lipid Research Center's Prevalence data,⁶ no matter what methodology is used.

Factors Affecting HDL

Hypertriglyceridemia.— Cross-sectional studies have shown an inverse correlation between total triglycerides and HDL-C.⁸ However, in longitudinal studies HDL-C has normalized only in Type III HLP and not in IV and V HLP when triglycerides are normalized by diet and/or weight loss.⁹⁻¹² However, the inverse relationship between the HDL-C and triglycerides found in cross-sectional studies may be a result of an increased rate of catabolism of triglyceride-rich lipoprotein by lipoprotein lipase (heparin stimulates the enzyme lipoprotein lipase), since the administration of heparin not only decreases triglyceride concentrations but increases HDL-C values. Furthermore, in Type I HLP (deficiency of lipoprotein lipase), there are extremely low levels of HDL-C.⁶

Physical activity.— There is ample evidence now that habitual physical activity is a powerful factor influencing HDL-C levels. Runners, skiers, and lumberjacks all have

significant increases in HDL-C associated with decreases in total triglycerides.⁶ The reason for this also may be increased catabolism of triglycerides with enhanced tissue lipase activity with HDL-C rising as a second catabolic product.⁷

Age, sex.— The effect of age on HDL in North America has shown that the mean HDL-C level is about 53 mg/dl in males and females from 0 to 14 years of age. In males after age 14 these levels drop to 44-46 mg/dl between 15 and 54 years of age, then rise to 51 mg/dl up to age 75. However, in females HDL-C levels of 53 mg/dl are maintained until age 25, and rise to 57 mg/dl between 26 and 40 years of age, and subsequently to a peak of 65 mg/dl by 65. Thus, women have higher HDL-C levels than men. Furthermore, it is well known that estrogen administration is followed by a definite rise in HDL and that opposite changes occur by the administration of testosterone.⁷

Alcohol.— Increases in HDL-C occur also with the administration of small and moderate amounts of alcohol (5 to 20 oz/week), even if total triglycerides are rising. A man who drinks 5 to 6 oz/day will have an HDL level about 10% higher than a man who does not drink at all.¹³ This also may occur by enhanced tissue lipase activity, although increased synthesis may occur as well.

Systemic diseases.— Alterations in HDL-C concentrations occur in a wide variety of systemic illnesses including renal disease and diabetes. The effects of diabetes have been variable on HDL-C levels probably because of the heterogeneity of glucose intolerance. Despite the complexity, in general, insulin-deficient diabetics have low HDL-C levels which usually return to normal with improvement of diabetic control (here also, the reason may be enhanced lipoprotein lipase activity since insulin stimulates this enzyme), and maturity onset diabetics have low HDL-C levels only if they have elevated plasma triglyceride levels.⁷

Drugs.— Lipid-lowering drugs associated with rises in HDL-C include clofibrate and nicotinic acid. The other commonly used drugs such as probucol or cholestyramine/colestipol have not been studied extensively, although colestipol has been shown not to affect HDL-C.¹⁴ Of practical importance is that diphenylhydantoin raises HDL-C and hydrochlorothiazide lowers it.⁷

Smoking, coffee.— Smoking also appears to be associated with a depression of HDL-C, and, with cessation of smoking, HDL-C returns to normal.¹⁵ The combined effects of drinking five or more cups of coffee may be additive in smokers having low HDL-C levels as well. Of interest is a recent study that showed a trend of higher HDL-C levels in persons who did not smoke or drink coffee, compared to coffee-consuming smokers.¹⁶

Nutrition.— Many nutritional factors influence HDL-C. In general, obesity is associated with reduced levels of HDL-C although it is unclear whether this is a

function of increased adipose tissue mass of positive energy balance.⁶ During weight loss HDL-C rises somewhat, along with decreases in total TG concentrations. The rise in HDL-C probably occurs because HDL is the principal acceptor of adipocyte cholesterol in human plasma. Acute increases in carbohydrate intake lead to reciprocal changes in triglyceride and HDL-C concentrations. However, chronic changes or modifying complex to simple sugar ratios have not been done. Dietary cholesterol produces only a small effect in increasing total serum cholesterol levels in man because of adaptive mechanisms.⁶ On the whole, there is also a modest increase in HDL-C. More important is the recent finding of Mahley that cholesterol feeding is associated with a rise in a cholesterol ester-rich lipoprotein particle called HDL_C that acts like LDL (the atherogenic lipoprotein particle).¹⁷ Increasing the polyunsaturated fat to saturated fat ratio has been used for years to treat various hyperlipidemias. However, there are few studies documenting any dramatic change in HDL-C even though LDL-C levels fall. There are virtually no studies done on the effect of fiber or protein content on HDL-C levels.

Summary

Patients are being noted not to have low HDL-C values. HDL-C levels that are decreased have been shown to be an independent risk factor in the development of atherosclerosis. Low levels are frequently seen with elevated triglyceride levels. Efforts should be made to modify HDL-C concentrations by weight loss, cessation of smoking, and lowering triglycerides. Currently there are no drugs approved for human use to elevate HDL-C levels but future research in this area soon should be accomplished. Information on nutritional perturbations on HDL-C levels is important and this remains a fruitful area for future research efforts.

Acknowledgement: The author appreciates the secretarial assistance of Ms. Eileen Summit in the preparation of this article.

References

1. Rhoads GG, Gulbrandsen CL, Kagan A: Serum lipoproteins and coronary heart disease in a population study of Hawaii Japanese men. *N Engl J Med* 294:293-298, 1976.
2. Barr DP, Russ EM, Eder HA: Protein-lipid relationships in human plasma in atherosclerosis and related conditions. *Am J Med* 11:480-493, 1951.
3. Miller GJ, Miller NE: Plasma-high-density-lipoprotein concentration and development of ischaemic heart disease. *Lancet* 1:16-19, 1975.
4. Gordon T, Castelli WP, Hjortland MC, et al: High density lipoprotein as a protective factor against coronary heart disease: The Framingham Study. *Am J Med* 62:707-714, 1977.
5. Glueck CJ, Gartside P, Fallat RW, et al: Longevity syndromes; familial hypobeta and familial hyperalpha lipoproteinemia. *J Lab Clin Med* 88:941-957, 1976.
6. Gotto AM Jr, Miller NE, Olivers MF (editors): High Density Lipoproteins and Atherosclerosis Proceedings of the 3rd Argenteuil Symposium Held Under the Auspices of the Foundation Cardiologique Princesse Liliane in Waterloo, Belgium on Nov. 7-8, 1977. Amsterdam: Elsevier/North Holland, 1978.
7. Witztum J, Schonfeld G: High density lipoproteins, a review. *Diabetes* 28:326-336, 1979.
8. Schaefer EJ, Levy RI, Anderson DW, et al: Plasma-triglycerides in regulation of HDL-cholesterol levels. *Lancet* 2:391-393, 1978.
9. Falko JM, Witztum JL, Schonfeld G, et al: Type III hyperlipoproteinemia: rise in high-density lipoprotein levels in response to therapy. *Am J Med* 66:303-310, 1979.
10. Witztum JL, Dillingham, Giese W, et al: Normalization of triglycerides in Type IV hyperlipoproteinemia fails to correct low HDL-cholesterol values. *Clin Res* 25:569A, 1977.
11. Falko JM, Witztum JL, Schonfeld G, et al: Dietary treatment of Type V hyperlipoproteinemia fails to normalize low HDL-cholesterol levels. *Ann Intern Med* 91:750-751, 1979.
12. Glueck CJ, Stein EA, Kashyap ML, et al: Persistent hyperlipoproteinemia. *Clin Res* 26:680A, 1978.
13. Castelli WP, Gordon T, Hjortland MC, et al: Alcohol and blood lipids. *Lancet* 2:153-155, 1977.
14. Witztum JL, Schonfeld G, Weidman SW: The effects of colestipol on the metabolism of very-low-density lipoproteins in man. *J Lab Clin Med* 88:1008-1018, 1976.
15. Witztum JL: Diagnosis and treatment of hyperlipidemia. *Hospital Med* 14:60-79, 1978.
16. Heyden S, Heiss G, Manegold C, et al: The combined effect of smoking and coffee drinking on LDL and HDL cholesterol. *Circulation* 60:22-26, 1979.
17. Mahley RW, Innerarity TL, Bersot TP, et al: Alterations in human high-density lipoproteins, with or without increased plasma-cholesterol, induced by diets high in cholesterol. *Lancet* 2:807-809, 1978. ☆☆☆

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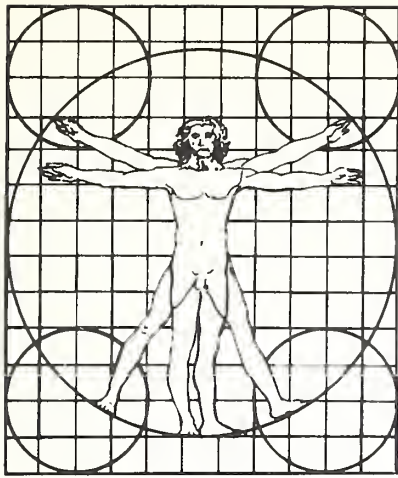
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CLINICAL & SCIENTIFIC

Cefamandole Nafate and Blood Coagulation

Galen M. Custer, M.D.
Bruce R. Briggs
Roy E. Smith, M.D.*

The effect of cefamandole nafate on platelet function and coagulation were tested both in vivo and in vitro. No changes in clotting function were observed after in vivo administration. In vitro, at extremely high concentrations ($>2,000 \mu\text{g/ml}$), distinct abnormalities were seen in both ADP- and collagen-induced platelet aggregation. Exposure of blood platelets to cefamandole nafate and penicillin G simultaneously, resulted in similar changes that could be overcome by incremental doses of aggregating agents. Neither platelets nor plasma from uremic patients was more susceptible to drug-induced alterations in clotting function. Our findings indicate that at therapeutic levels, cefamandole nafate has no adverse effect on clotting function.

VARIOUS CLASSES of antibiotics have been implicated as causative factors in acquired hemostatic defects.^{1,4} Failure to recognize this association has had disastrous consequences.^{1,2,4} On occasion this association was not recognized until after the antibiotic was introduced for general use.

Antibiotics shown to induce specific defects in hemostasis include: penicillin and its derivatives,^{1,4,5} nitrofurantoin,⁶ and the cephalosporins.^{2,3,5,7} An example is the inhibition of adenosine diphosphate (ADP) and epinephrine-induced platelet aggregation by carbenicillin infusion.^{1,2,4,5}

Similarly, abnormal platelet aggregation has been demonstrated *in vitro* in the presence of cephalothin.^{5,7,8} The other cephalosporin antibiotics have not been shown

specifically to induce abnormal platelet function,^{5,7} however, they have occasionally been implicated in significant bleeding episodes in uremic patients.³

We examined the effect of a new cephalosporin antibiotic, cefamandole nafate (Mandol®) on platelet function and hemostasis.⁹ The antibiotic is widely distributed after parenteral administration and is excreted primarily by renal tubular secretion.¹⁰⁻¹² Peak serum levels following a 2-gram intravenous dose are in the range of 100 to 500 $\mu\text{g/ml}$ and are reached within ten minutes after the completion of infusion.¹³

In the presence of renal impairment, however, urinary excretion is slowed and serum half-life prolonged. Failure to adjust the dose of drug administered in this setting is expected to result in excessive serum levels.¹²

In the following study, we examined the effect of cefamandole nafate infusions on platelet function in normal volunteers and patients. We then tested the effects of various concentrations of the drug on normal platelet function and coagulation *in vitro*.

In addition, since high concentrations of the drug are expected to be seen in the setting of renal failure, we obtained platelet and plasma samples from uremic volunteers, and studied the effects of a wide range of cefamandole nafate concentrations on platelet function and blood coagulation.

Finally, we examined the combination of high levels of penicillin G and cefamandole nafate for synergistic effects on ADP- and collagen-induced platelet aggregation *in vitro*.

Materials and Methods

Subjects.—Volunteers were recruited from the hospital staff and patients of the Ohio State University Hospitals. All subjects receiving cefamandole nafate denied histories for either allergy to penicillins and cephalosporins, peptic ulcer disease, bleeding tendency, or thrombophlebitis. Before receiving the drug, all subjects were determined to have normal hemostatic function and were required to give their informed consent.

From the Department of Medicine, Division of Hematology and Oncology, The Ohio State University Hospitals, Columbus, Ohio.

Reprint requests to 410 West Tenth Ave., Columbus, Ohio 43210 (Dr. Smith).

*Recipient of the 1978-1979 Central Ohio Heart Association's Young Investigatorship grant.

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Cefamandole Nafate Administration.— Six normal subjects and two infected patients were given 2-gram intravenous infusions of cefamandole nafate over 15 to 30 minutes. Ten to 15 minutes after completion of infusion, blood was obtained for platelet function evaluation. The six normal subjects were tested after one-time infusions, while the two patients had received a total of eight doses each over 48 hours.

Blood Coagulation and Platelet Function Tests.— All blood coagulation and platelet function tests were performed using standard methods. Tests done after drug administration included platelet count (Coulter Model B, Coulter Electronics, Inc., Hialeah, Fla.); bleeding time (General Diagnostics, Cincinnati, Ohio); platelet retention,¹³ and platelet aggregation induced by 1 to 4 μ M/ml ADP (Chronolog, Havertown, Pa.); 10 to 20 μ g/ml of epinephrine (Chronolog, Havertown, Pa.); 0.2 to 0.4 mg/ml collagen (Chronolog, Havertown, Pa.); and 1.5 mg/ml of ristocetin (H. Lundbeck, Denmark). A dual channel aggregometer (Payton Assoc., Inc., Buffalo, New York) was used and evaluations made for alterations in the aggregation rate, lag phase, disaggregation rate, maximum percent aggregation, and the presence or absence of a secondary wave of aggregation.

The aggregation rate was defined as the slope of a line drawn through the steepest portion of the aggregation curve following the addition of the aggregating agent. The disaggregation rate was designated as the slope of a line drawn through the steepest portion of the aggregation curve after maximum aggregation. Lag phase was the time from the addition of the aggregating agent to the beginning of the primary wave of aggregation. Maximum aggregation was the maximum difference in

the percent of light transmittance within four minutes after the addition of the aggregating agent. Results were compared with baseline studies done at a time remote from the cefamandole nafate infusion.

Blood samples were obtained from three normal and three uremic subjects that had not taken platelet-inhibiting drugs for at least ten days. One stage prothrombin time (PT), activated partial thromboplastin time (APTT), and reptilase time were performed using an automated clot timer (Coagulizer Jr. Lancer, Div. of Sherwood Medical, St. Louis, Missouri). Thrombin time, fibrinolytic activity, fibrinogen titers, and platelet factor 3 availability were assayed by standard methods.¹⁴⁻¹⁶

Values were determined in plasma samples after 15 minutes' incubation with and without incremental concentrations of cefamandole nafate ranging from 200 to 800 μ g/ml. PRP from the three normal and three uremic subjects were incubated with cefamandole nafate and their aggregation responses to ADP, collagen, and ristocetin were determined as described previously.

In addition, PRP from three normal subjects was incubated with inhibitory concentrations of either cefamandole nafate alone, penicillin G alone, or both drugs simultaneously. Then they were aggregated with incremental doses of either ADP or collagen to determine the reversibility of inhibition.

All experiments were done in duplicate with simultaneous controls using volumes of normal saline equal to the volume of the antibiotic solution which was added to test samples in each case.

Results

Effects of Cefamandole Nafate Infusion on Platelet Function.— As seen in Table 1, Subject 6 had abnormal

Table 1
Platelet Function Following Cefamandole Nafate
Administration in Normal Volunteers and Patients

	Subjects								Normal Range
	1	2	3	4	5	6	7	8	
Simplate* Bleeding Time	—/9	6/6	—/5	5/6	9/9	5/5	—/5	—/5	3-9
Platelet Retentions	—/60	53/48	—/27	46/61	34/54	67/77	—/37	—/49	37-87
P A Collagen L G %	83/63	80/60	—/73	77/65	70/75	63/75	—/73	—/75	66-83
A G ADP T R %	87/38	77/75	—/75	85/88	80/90	68/74	—/65	—/82	64-80
E E Epi L G %	—/73	75/88	—/88	75/80	80/83	25/63	—/80	—/85	65-87
E A Ristocetin T T %	83/90	93/93	—/82	95/100	90/83	90/90	—/90	—/92	85-95
I O N									

*All values expressed as Predose/Postdose

(—) = Not done

Platelet aggregation expressed as % maximum aggregation

baseline responses to collagen and epinephrine. Otherwise, all six normal subjects had aggregation values within the normal range for our laboratory.

Infusion with therapeutic doses of cefamandole nafate resulted in decreased maximum response to collagen in Cases 2 and 4, and an increased response to epinephrine in Case 6. Remote baseline values were not obtained for Subject 3 because of subsequent aspirin abuse, and in Subjects 7 and 8, because of prolonged infusions for therapeutic purposes.

No subject had a significant alteration in platelet retention, but Case 5 had a low baseline value. There were no changes in the bleeding time.

Effect of Varying Concentrations of Cefamandole Nafate on Normal Platelet Function and Coagulation.—Plasma and PRP samples from three normal volunteers were incubated with concentrations of cefamandole nafate ranging from 200 to 800 $\mu\text{g/ml}$. Thrombin time, reptilase time, fibrinogen titer, fibrinolytic activity, and platelet factor 3 availability remained unchanged.

PT, APTT, and collagen, ristocetin and ADP-induced platelet aggregation remained unchanged after incubation with 200 to 2,000 $\mu\text{g/ml}$ of cefamandole nafate. However, incubation with concentrations of cefamandole nafate greater than 2,000 $\mu\text{g/ml}$ resulted in abnormal responses in all three subjects.

When stimulated by ADP, all subjects had a decreased percent maximum aggregation, increased rate of disaggregation, and inhibition of the release reaction as the concentration of cefamandole nafate was increased. Collagen-induced aggregation was characterized by marked increases in the lag phase and minor decreases in the rate of aggregation. Two subjects had decreases in maximum percent aggregation in response to collagen.

Ristocetin-induced aggregation was unaffected except for a slight decrease in the rate of aggregation in one subject. Typical maximum percent aggregation responses to ADP and collagen with and without preincubation with cefamandole nafate are illustrated in Figure 1.

In the presence of 4,000 $\mu\text{g/ml}$ or greater of cefamandole nafate, significant prolongations in PT and APTT were noted in all three normal subjects. To show that this was not a simple dilutional effect, equivalent volumes of saline were added in parallel determinations and no similar prolongations were seen.

Coagulation factor assays were performed on plasma from one of these individuals which had been incubated with 8,000 $\mu\text{g/ml}$ of the drug. No change in any plasma factor activity was detected.

Effect of Varying Concentrations of Cefamandole Nafate on Platelet Function and Coagulation of Uremic Patients.—Blood samples were obtained from uremic volunteers at a time when their BUN and serum creatinine levels ranged from 61 to 88 mg/dl and 13.1 to 18.0 mg/ml , respectively. Tests of platelet function and coagulation were performed in the presence of increasing concentrations of cefamandole nafate as described in the previous section.

All baseline values were normal. As seen in Table 2, all uremic patients had changes in platelet aggregation in the presence of incremental concentrations of the antibiotic. Observed abnormalities were induced with cefamandole nafate concentrations greater than 4,000 $\mu\text{g/ml}$ except in Patient 11 in which the maximum percent of ADP-induced aggregation was decreased and

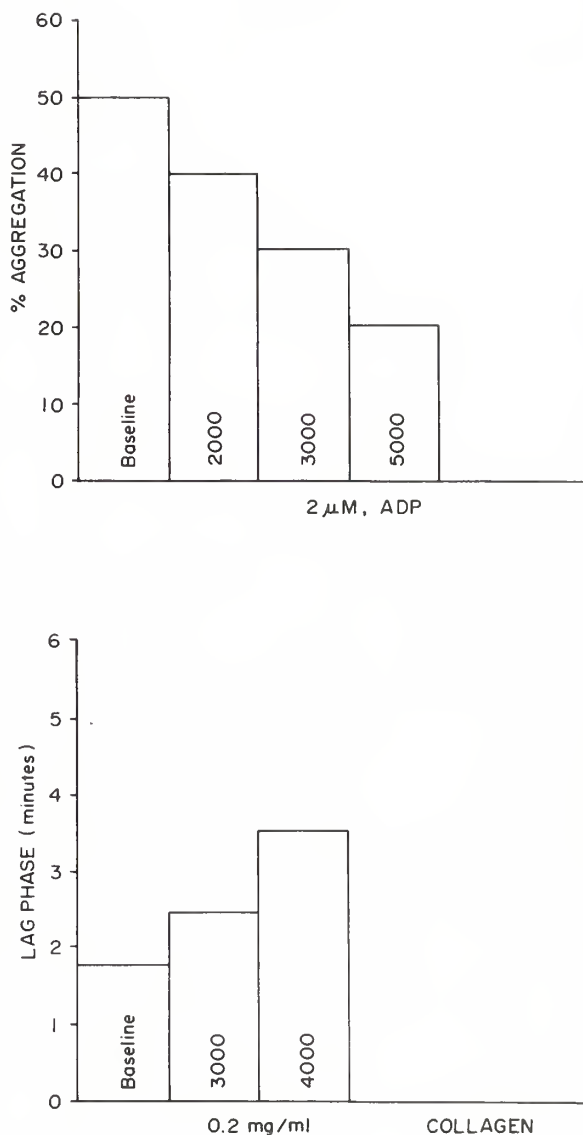


Fig. 1. Representative platelet aggregation responses with and without preincubation with cefamandole nafate. *Top panel:* Aggregation induction by 2 μM ADP showing baseline maximum percent aggregation and following incubation with 2,000 $\mu\text{g/ml}$, 3,000 $\mu\text{g/ml}$, and 5,000 $\mu\text{g/ml}$ cefamandole nafate respectively. *Bottom panel:* Aggregation induction by 0.2 mg/ml collagen showing baseline lag phase time and those following incubation with 3,000 $\mu\text{g/ml}$ and 4,000 $\mu\text{g/ml}$ cefamandole nafate respectively.

the rate of disaggregation increased after incubation with 400 $\mu\text{g}/\text{ml}$ of the drug, and Patient 9 in which the maximum percent collagen-induced aggregation was impaired at 200 $\mu\text{g}/\text{ml}$.

As with the normal subjects, thrombin time, reptilase time, fibrinogen titers, fibrinolytic activity, and platelet factor 3 availability remained unchanged. The PT and APTT were prolonged in the presence of 4,000 $\mu\text{g}/\text{ml}$ or greater of cefamandole nafate in two of the uremic patients. No prolongation was seen in one. This difference did not appear to be related to the degree of elevation of either the BUN or serum creatinine.

Effect of Simultaneous Exposure to Both Cefamandole Nafate and Penicillin G on Platelet Aggregation.

— In separate experiments, to test for possible synergistic effects, platelets were exposed to high doses of penicillin G (a known inhibitor of aggregation), in addition to cefamandole nafate.

At high levels, both drugs individually resulted in decreased maximum percent ADP-induced aggregation. Exposure to high levels of both drugs simultaneously resulted in similarly decreased maximum percent aggregation; however, a definite increase in the rate of disaggregation also was noted. These effects were partially overcome by incubation with increased amounts of ADP (Fig. 2).

When collagen was used as the aggregating agent, preexposure to both drugs individually resulted in marked prolongation of the lag phase with relative preservation of maximum percent aggregation. After exposure to high levels of both drugs, lag phase prolongation was still more pronounced, again with preservation of maximum percent aggregation. As in the case with ADP induction, these effects were overcome largely by incubation with larger amounts of collagen (Fig. 2).

Discussion

Our findings indicate that cefamandole nafate, at usual therapeutic levels, has no deleterious effects on hemostatic integrity. Single intravenous bolus injections resulted in no postdose abnormalities in the platelet function of six normal subjects. Similarly, prolonged multiple doses did not alter platelet function from normal in two infected patients.

In vitro testing of platelet function and plasma coagulation after incubation with incremental concentrations of the antibiotic resulted in no significant abnormalities at levels reasonably attainable in clinical situations.

At high concentrations, cefamandole nafate induced prolongations of the PT and APTT in uremic and normal subjects. Similar changes in coagulation have been reported with cephalosporin administration;^{3,6} however, associated with this were thrombin time prolongation and elevation in fibrin degradation products suggesting these changes were due to retarded fibrinogen-fibrin polymerization.

Our findings do not support this mechanism for a cefamandole nafate-induced coagulopathy, since we

found no change in thrombin time, reptilase time, fibrinogen titers, or fibrinolytic activity despite incubation with high concentrations of cefamandole nafate. We found no evidence that plasma from uremic patients was more sensitive to alterations by an antibiotic.

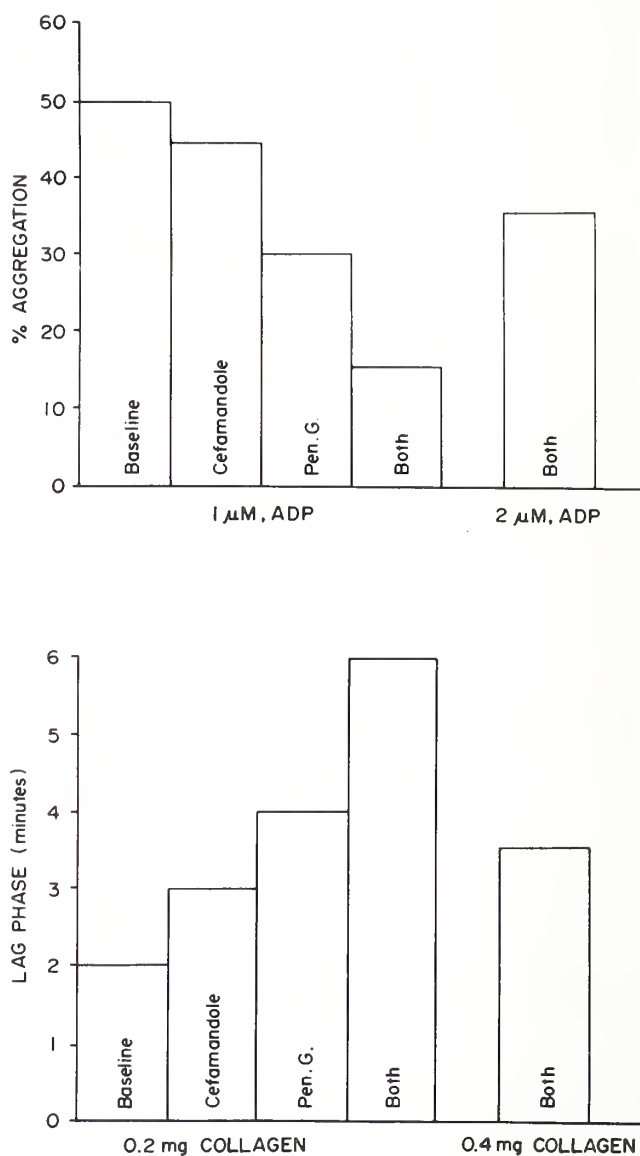


Fig. 2. Representative platelet aggregation responses with and without preincubation with cefamandole nafate, penicillin G, or both. *Top panel:* Aggregation induction by 1 μM ADP showing baseline response and those following incubation with cefamandole nafate (1,000 $\mu\text{g}/\text{ml}$) alone, penicillin G (2,000 $\mu\text{g}/\text{ml}$) alone, and both cefamandole nafate and penicillin G, respectively. Also shown is the effect of doubling the amount of ADP used for induction following incubation with both drugs. *Bottom panel:* Aggregation induction by 0.2 mg collagen showing lag phase time at baseline and following incubation with cefamandole nafate, penicillin G, and both drugs respectively. Also shown is the effect of doubling the amount of collagen used for induction following incubation with both drugs.

Table 2
The Effect of Cefamandole Nafate on Platelet
Aggregation From Uremic Patients

		ADP	Collagen	Ristocetin
Lag Phase	9	o	o	o
	10	o	+	o
	11	o	+	o
Max. % Aggregation	9	o	—	o
	10	—	—	—
	11	—	—	o
Disaggregation Rate	9	o	o	o
	10	+	o	o
	11	+	o	o
Aggregation Rate	9	o	o	o
	10	o	—	—
	11	o	—	o
2° Aggregation	9	—	o	o
	10	—	—	o
	11	—	o	o

(—) decreased (+) increased (o) no change

Alterations of ADP, collagen, and ristocetin-induced aggregation also occur in the presence of very high concentrations of cefamandole nafate. The pathogenesis of these abnormalities is unclear, although the pattern is similar to that reported with semisynthetic penicillins,^{1,3} as well as cephalothin and cephalotin.^{3,5,7}

The results of ADP-induced aggregation studies in which maximum percent aggregation was decreased, secondary aggregation abolished, and the rate of disaggregation increased, suggests that this drug interferes with ADP-platelet receptor reactivity. This hypothesis is supported by the relatively intact collagen-induced aggregations with marked prolongations in the lag phase implying that the intraplatelet adenine nucleotide pool was intact. Further support is provided by the aggregation findings in the presence of both penicillin G and cefamandole nafate.

Particularly interesting was the reversibility of inhibition of aggregation with increased amounts of ADP and collagen. However, since we did not measure the intracellular adenine nucleotides in these subjects, we cannot be certain of this interpretation. Interestingly, alterations in ADP and collagen-induced platelet aggregations were seen more readily in platelets from two of our uremic patients at relatively low doses of the antibiotic.

It should be pointed out that we did not investigate the hemostatic effect of prolonged cefamandole nafate administration. While our findings indicate the relative lack of hemostatic effect following brief exposure to clinically attainable concentrations of the drug, it remains possible that more extended drug administration

might result in a coagulopathy not revealed by our results. Such a delayed effect has been reported previously with cephalothin.⁶

The coagulation and platelet function changes we have demonstrated at very high concentrations of cefamandole nafate might best be regarded as clinical possibilities if the drug is used imprudently. In any case, excessively high serum levels probably should be avoided by dose reductions in the setting of severe renal disease.

References

1. Andrassy K, Weischedel E, Ritz E, et al: Bleeding in uremic patients after carbenicillin. *Thromb Haemostas* 1976;36(1):115-126.
2. Brown CH III, Natelson EA, Bradshaw W, et al: The hemostatic defect produced by carbenicillin. *N Engl J Med* 1974;291:265-270.
3. Lerner PI, Lubin A: Letter: Coagulopathy with cefazolin in uremia. *N Engl J Med* 1974;290:1324.
4. Cazenave JP, Packham MA, Guccione MA, et al: Effects of penicillin G on platelet aggregation, release, and adherence to collagen. *Proc Soc Exp Biol Med* 1973;142:159-166.
5. Johnsson H, Niklasson PM: Effects of some antibiotics on platelet function *in vitro* and *in vivo*. *Thromb Res* 1977;11(2):237-251.
6. Rossi EC, Levin NW: Inhibition of primary ADP-induced platelet aggregation in normal subjects after administration of nitrofurantoin (furadantin). *J Clin Invest* 1973;52:2457-2467.
7. Natelson EA, Brown CH III, Bradshaw MW, et al: Influence of cephalosporin antibiotics on blood coagulation and platelet function. *Antimicrob Agents Chemother* 1976;9(1):91-93.
8. Cazenave JP, Guccione MA, Packham MA, et al: Effects of Cephalothin and penicillin G on platelet function *in vitro*. *Brit J Haematol* 1977;35(1):135-153.
9. Custer GM, Briggs BR, Smith RE: Effect of cefamandole nafate on blood coagulation and platelet function. *Antimicrob Agents Chemother* 1979;16(6):869-872.
10. Griffith RS, Black HK, Brier GL, et al: Cefamandole: *In vitro* and clinical pharmacokinetics. *Antimicrob Agents Chemother* 1976;10(5):814-823.
11. Shemonsky NK, Carrizosa J, Levison ME: *In vitro* activity and pharmacokinetics in patients of cefamandole, a new cephalosporin antibiotic. *Antimicrob Agents Chemother* 1975;86:679-683.
12. Mellin HE, Welling PG, Madsen PO: Pharmacokinetics of cefamandole in patients with normal and impaired renal function. *Antimicrob Agents Chemother* 1977;11(2):262-266.
13. Grose WE, Bodey GP, Stewart D: Observations in man on some pharmacologic features of cefamandole. *Clin Pharmacol Ther* 1976;20(5):579-584.
14. Weiss HJ: *Platelet adhesiveness (retention)*. In: *Hematology*. 2d ed. Edited by William J. Williams, Ernest Beutler, Allan J. Erslev, et al. New York: McGraw-Hill, 1977, pp 1656-1657.
15. Jim RT: A study of the plasma thrombin time. *J Lab Clin Med* 1957;50(1):45-60.
16. Buckell M: The effect of citrate on euglobulin methods of estimating fibrinolytic activity. *J Clin Pathol* 1958;11:403-405.
17. Hardisty RM, Hutton RA: Platelet aggregation and the availability of platelet factor 3. *Brit J Haematol* 1966;12:764-776.

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Please consider participating in the OSMA Key-Physician Program. Your involvement is vital.

FAIR PLAN SNAGS

A Republican-backed "antigerrymandering" proposal has apparently failed to gain sufficient signatures (284,000) for placement on the General Election ballot. The Committee for Fair and Impartial Redistricting (FAIR) collected more than 320,000 signatures. However, 91,000 of the signatures were disqualified by Secretary of State Anthony J. Celebrezze, Jr., because the signatures were on petitions which differed slightly from the remaining petitions. The Ohio constitution requires that each petition contain a "full and correct copy" of any proposed constitutional issue.

The FAIR plan, a proposed constitutional amendment, would provide for the redistricting of legislative seats in Ohio on the basis of a mathematical formula that measures district compactness.

The FAIR committee vigorously supported by the Republican Party, filed suit in the Ohio Supreme Court to force the Secretary of State to process all the petitions to place the issue on the ballot. The executive director of FAIR, George Pfeiffer, stated that he had not been aware of the discrepancy in the petitions, but that he felt all petitions meet the constitutional requirement. He charged Celebrezze, a Democrat, with a "classic example of partisan politics at its worse."

The FAIR plan would create a redistricting procedure which would tend to favor the Republican Party. The proposal would divide the state into units of 4,000 population following each federal census. These units would follow as closely as possible the boundaries of townships, cities, and census tracts. The units would be used as building blocks for assembling compact state legislative and congressional districts.

Alternative redistricting plans, based on these population units, would be reviewed by a Commission for Reapportionment and Redistricting, composed of two Republicans, two Democrats, and a fifth member chosen by these four partisan members. The commission would rate the alternative plans by a mathematical formula measuring "compactness." The plan with the highest compactness ratio would become the official plan for the next 10 years.

Democrats, who oppose the FAIR plan, have been accused of favoring old-fashioned, back-room power politics. The FAIR plan, however, would tend to lock the Democrats into a limited number of districts. Democratic electoral strength lies in urban areas. The compactness formula of the FAIR plan would isolate this Democratic strength into a number of heavily Democratic inner-city districts.

Currently, the Democrats control the state legislative redistricting procedure undertaken after each decennial federal census. Under the Ohio constitution redistricting is the responsibility of a five-member apportionment board, composed of the Governor, the Auditor of State, the Secretary of State, and one person from each party appointed by the leaders of the House and the Senate. Because the Secretary of State and the Auditor, both elected in 1978, are Democrats, the Democrats have a 3 to 2 majority on the apportionment board. The advantage of apportionment control has been well documented in the past 20 years.

As a result of a number of major cases beginning in 1962, the "one-man, one-vote" doctrine was established by the U.S. Supreme Court, which developed population standards for redistricting state legislative and congressional electoral districts. Essentially, the U.S. Supreme Court acted to impose population as the basis of representation. The Court compelled the states to apportion both houses of their legislatures on population and to create substantially equal state legislative and congressional districts.

Prior to this "reapportionment revolution" of the 1960s, population was only one basis for apportionment. Land — units of territory such as counties and townships — had served as another, often predominant basis. Mass movements of population and the growth of great industrial centers during the 20th century produced increasing population disparities among counties and other electoral units. However, state legislators, owing their elections to the existent system, were often unwilling to reapportion. Rurally-dominated legislatures in the states tended to perpetuate themselves, until the Court ordered population-equal districts.

"Gerrymandering" — redistricting for partisan or other political purposes — is, then, an American political tradition. While the Court changed the rules of the apportionment game, considerations of incumbency and partisan politics remain.

Ohio legislators first ran in single-member districts in 1966 under a plan drafted by a Republican-controlled apportionment board. Democrats lost six Senate seats and won only 37 of the 99 new House seats. By 1970, the last year of the Republican plan, Democrats had picked up only 3 additional Senate seats and 8 more House seats, despite a Democratic landslide in statewide races.

The present districts were drawn by a Democratic-controlled board in 1971. In the 1972 election the Republicans lost 3 seats in the Senate, still a 17 to 16 majority; however, the Republicans lost control of the House, in which the Democrats gained 13 seats for a 58 to 41 majority.

In 1974 the Democrats won 5 additional Senate seats to gain control of that chamber for the first time since the late 1950s. Currently, the Democrats control the Senate with an 18 to 15 majority and the House with a 62 to 37 margin.

Unless the FAIR plan is ordered on the November ballot by the Ohio Supreme Court or by a federal court on appeal, the Democrats will control the redistricting process in 1981. The result will be a district structure favorable to the Democrats through the decade of the 1980s.

FEDERAL

BUDGET RECONCILIATION HELD UP IN THE HOUSE

The Congressional budget process received a major setback Tuesday (July 29) as the House Rules Committee was unable to agree on a rule for debating HR 7765, the reconciliation bill. The bill originally had been scheduled for floor debate on Wednesday, July 30. That has now been postponed until after the upcoming recess which ends August 18. This delay is in contrast to the remarkable ease with which the Senate passed its reconciliation bill.

An unsuccessful effort was made Wednesday (July 30) to call another session of the Rules Committee. That failure prompted the House Budget Committee to call an emergency meeting Thursday morning (July 31) to find a way to agree on a rule acceptable to all parties. Negotiations were proceeding in the hope that a rule could be hammered out before the House recessed at the end of the day on Friday (August 1).

The Thursday Budget Committee meeting was punctuated by noisy debate, especially over an amendment sponsored by Representative Delbert Latta (R-Ohio), the ranking minority member on the Committee. His amendment would strike many of the provisions in HR 7765 that would expand certain benefits under Medicare-Medicaid. These provisions came out of HR 3990 and HR 4000 and were inserted, along with savings provisions, by the Interstate and Foreign

Commerce and Ways and Means Committees. The Rules Committee had earlier rejected Latta's amendment.

Budget Committee Chairman Robert Giaino (D-Conn.) warned Latta that his amendment would lose on the floor, but Latta insisted that the amendment be permitted. He argued strongly that it made no sense to include cost increases in a bill designed to reduce federal expenditures.

At that time, Giaino seemed willing to allow a vote on Latta's amendment as the only way to get the reconciliation bill to the floor.

LAB PERSONNEL STANDARDS DELAYED

Last October the Health Care Financing Administration (HCFA) and the Center for Disease Control issued a Notice of Proposed Rulemaking calling for the establishment of personnel standards for hospital clinical laboratories. At this time, it appears that this proposal will not be finalized.

According to an internal HHS memo, the Department feels that it is essential to prove the correlation between stringent personnel standards and higher quality laboratory test results to justify the need for the personnel standards. To date, the Department has failed to obtain any data to prove this point. CDC held three days of public hearings to obtain such information, yet no group came forward with evidence confirming a direct link between formal personnel standards and lab quality.

NURSING HOME CONDITIONS OF PARTICIPATION ANNOUNCED

After months of internal deliberations, the Department of Health and Human Services has finally released proposed conditions of participation for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF) in the Medicare and Medicaid program. While these conditions were expected to be of interest to the medical profession, there was little idea of just how controversial they would be. The Health Care Financing Administration (HCFA) is proposing to define the term "physician" to include not only physicians (as currently defined in

law), but also physician's assistants and nurse practitioners. Under the proposal, a "physician" would be defined as: a "doctor of medicine or osteopathy licensed under state law to practice medicine or surgery, as specified in Section 1861 (r) (1) of the Social Security Act. Where state law permits, the term 'physician' includes a physician-directed team of physician assistants and nurse practitioners. Direction need not be on-site."

The proposed regulation does not define either nurse practitioner or physician assistant, and there is no delineation made in the conditions concerning what services could be appropriately performed by the physician assistant or nurse practitioner. As drafted, it would be possible for a patient to enter a nursing home, be placed under a care regimen, receive follow-up visits for an extended period of time, and possibly never see a physician.

The draft regulatory analysis that was prepared to accompany the proposed conditions discusses the use of physician extenders. Such use is justified because of "lack of involvement of physicians in the care of long-term patients." Reasons given by HCFA for this lack of involvement include lack of interest in the "incurable problems" of the elderly, lack of medical education oriented toward geriatrics and the chronically ill, and the inadequate reimbursement and time-consuming paperwork burdens imposed by third-party payers such as Medicare and Medicaid. No objective data was offered to justify these reasons.

NHI ACTION

Catastrophic Insurance Bills: Senate Finance Committee markup continues on S 350, S 351, S 760 (Long) and S 748 (Dole). **Pro-Competition Bills:** Hearings held by Senate Finance Committee on S 1968 (Durenberger) and by Ways and Means on HR 5740 (Ullman). **Universal Insurance Bills:** There has been no Senate action on the Administration's or Kennedy's universal insurance bills (S 1812 or S 1720), which are pending in Senate Finance Committee and Senate Labor and Human Resources Committee. Joint hearings were held by House Interstate & Foreign Commerce and Ways and Means on the House versions of these bills (HR 5191 and HR 5400).

Status of Selected Health Legislation

BILL	No. & Sponsor	Committee	Action
Budget Reconciliation	HR 7765 Giaino	HBC	In Rules Committee
	S 2885 Hollings	SBC	Passed Senate
Child Health Assurance (CHAP)	HR 4962 Waxman	IFC	Passed House
	S 1204 Ribicoff	SFC	Committee report
Clinical Laboratories Regulation	S 590 Javits	SHR	Committee report
	HR 4894 Waxman	IFC, W&M	—
Drug Reform	S 1075 Kennedy	SHR	Passed Senate
	HR 4258 Waxman	IFC	Subcommittee hearings
FTC Authorization	HR 2313 Scheuer		PL 96-252
Food Labeling	S 1651 McGovern	SAN	Subcommittee hearings
	S 1652 McGovern	SCS, SHR	SHR Subcommittee hearing
Health Manpower	HR 7203 Waxman	IFC	Committee report
	S 2375 Kennedy	SHR	Com. report ordered
Hospital Cost	HR 2626 Rangel	IFC, W&M	Passed House (w/Gephardt Substitute)
	S 570 Nelson	SFC, SHR	Tabled in SFC; SHR report ordered
Lobbying Regulation	HR 4395 Rodino	HJC	Reported by Committee
	S 2160 Chiles	SGA	Committee markup
Medical Records	HR 5935 Preyer	HGO, IFC, W&M	HGO, IFC Com. rpts; W&M Sub. hearings
	S 503 Javits	SGA, SJC	SGA Com. report ordered
Medicare/Medicaid	HR 934 Talmadge	SFC	Committee report
	HR 3990, Rangel	IFC, W&M	IFC, W&M Committee reports
	HR 4000	IFC, W&M	IFC, W&M Committee reports
Mental Health Services Improvement	HR 7299 Waxman	IFC	Committee report
	S 1177 Kennedy	SHR	Passed Senate
Military Pay	S 2460 Hart		PL 96-284
NIH Reorganization	HR 7036 Waxman	IFC	Committee report
	S 988 Kennedy	SHR	Passed Senate

Committee Abbreviations:

HAS: House Armed Services
 IFC: House Interstate & Foreign Commerce
 HBC: House Budget
 HGO: House Government Operations
 HJC: House Judiciary
 W&M: House Ways and Means
 SAN: Senate Agriculture, Nutrition & Forestry

SBC: Senate Budget
 SCS: Senate Commerce, Science & Transportation
 SFC: Senate Finance
 SGA: Senate Governmental Affairs
 SHR: Senate Labor and Human Resources
 SJC: Senate Judiciary
 Sub: Subcommittee
 Com.: Committee

Features

The 1980's Physician (Part II) From Patient Advocate to Health-Care Captain 542

Karen S. Edwards

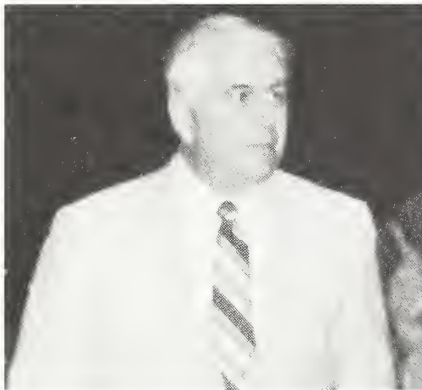
Last month, OSU Marketing Professor Roger Blackwell, Ph.D., explained how physicians are going to have to become more involved in making moral and economic decisions. This month, Dr. Blackwell explores what might happen if the 1980's physician ignores this responsibility.



Honor Behind the Lines: The 1980 Sports Medicine Awards 546

Robert D. Clinger

Seven Ohio physicians, who have donated a combined 143 years of medical service to high school football teams, were recently honored in Canton, Ohio. The *Journal* provides profiles, pictures and a story of special recognition.



Physicians' Fees in Perspective 551

Edward Zalta, M.D.

How does the increase in physicians' fees during the past 13 years stack up against the increases of attorneys' fees, postage, energy and running government? This article, reprinted from the *LACMA Physician*, details it all for you.

Death or Divorce: Coping with Loss 557

Pamela Jelly, R.N. and Eric C. Jelly, M.D.

Physicians often rely so heavily on their roles as caretaker and lifesaver, that they find their own personal loss difficult to handle. A husband and wife research team discusses in this article the best way for physicians to cope with personal loss.

Our Cover

This month's cover photograph was another "Outstanding Entry" in this year's *Journal* Photographic Contest. Titled "Autumn Reflections," Joseph M. Wilson, M.D., Dayton, captured this peaceful scene on an October morning in New Hampshire with a Pentax 35 mm. camera, using a 1:35/35 lens and Kodachrome 64 film.

AMA Outlook 563

Oscar Clarke, M.D. and Robert Thomas, M.D.

This report from the AMA annual meeting includes action taken on regionalization of medical services and CT Scanning — the two resolutions introduced by the Ohio Delegation — as well as the revised Medical Ethics issue.

Clinical and Scientific

Medical Hyperbaric Oxygen Therapy: 22 Cases 582

Frank Welsh, M.D.

Luis Matos, M.D.

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National

Karl S. Messerly
United Media Associates, Inc.
16 Bruce Park Avenue
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...to the editor

To the Editor:

I am writing you to compliment you and the staff of the *OSMA Journal* on the appearance and format of the *Journal* in recent months. It has become quite attractive and actually **interesting**. The current issue (July) is a prime case in point. Karen Edwards did an outstanding job with that essay on the Marathon.

All of you deserve applause for transforming this previously pedestrian periodical into an attractive, readable, and interesting publication.

Kindest regards,
/s/Warren W. Smith, M.D.
Columbus, Ohio

To the Editor:

Just got the July issue of the *Journal*, and it looks fantastic! The graphics are really attractive, and the new departments very innovative.

You and the *Journal* staff are to be congratulated — let me know which awards you win this year!

Regards,
/s/Linda P. Trafford

Director of Communications
Physicians Insurance Company of Ohio
Columbus, Ohio

To the Editor:

I have just returned from the AMA meeting in Chicago and was most pleasantly surprised when I opened my copy of the *Ohio State Medical Journal*. Your article "The Road to Boston" was excellent, not only the content but the creativeness was outstanding. It will definitely be an important part of my memoirs.

Regards,
/s/Jack Schreiber, M.D.
Canfield, Ohio

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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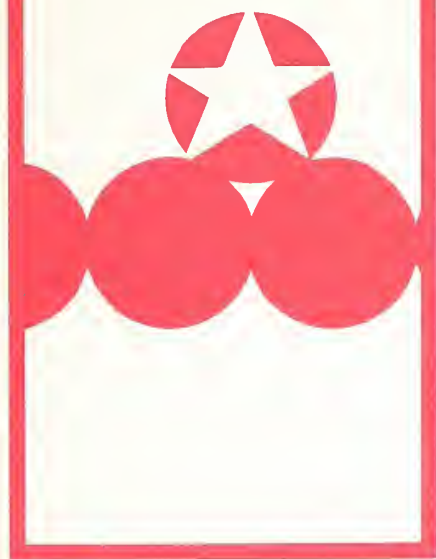
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COLLEAGUES IN THE NEWS



ROMEO BACHAND, M.D., Lake County, was elected to the board of trustees of the Northeast Ohio Affiliate of the American Heart Association.

MALCOLM BRAHMS, M.D., Beachwood, **BELDEN GOLDMAN, M.D.**, Shaker Heights, and **HARVEY POST, M.D.**, Shaker Heights, were awarded pins of recognition for 25 years of service at Mt. Sinai Hospital's annual meeting.

PHILIP CARAVELLA, M.D., Rocky River, was elected president of the Cleveland Academy of Family Physicians. Dr. Caravella is an assistant clinical professor at Case Western Reserve University School of Medicine and regional director of the Ohio Academy of Family Physicians Board of Directors.

EDWARD CHARNOCK, M.D., Upper Sandusky, was appointed medical director of the department of emergency medicine at Community MedCenter Hospital.

On June 19, **C.M. DOUGHERTY, M.D.**, New Philadelphia, was presented with a special "Certificate of Distinction," at a dinner at the Union Country Club, hosted by the Tuscarawas County Medical Society and Auxiliary. The certificate honored Dr. Dougherty's many years of service to his profession and his community.

The Julius E. Goodman Award was presented to **STUART FISHER, M.D.**, Cleveland, at Mt. Sinai Hospital's annual meeting. Dr. Fisher is chief of the hospital's division of dermatology and a member of the medical staff since 1959.

NOBLE F. FOWLER, M.D., Cincinnati, was reelected president of the Southwestern Ohio Chapter of the American Heart Association. Dr. Fowler is professor of medicine and director of the division of cardiology at the University of Cincinnati College of Medicine.

GARY FREEMAN, M.D., Beachwood, was named director of Mt. Sinai Hospital's department of anesthesiology. Dr. Freeman is an assistant clinical professor at Case Western Reserve University's School of Medicine.

WILLIAM GERHARDT, M.D., Cincinnati, was one of 75 Ohio representatives chosen to attend the White House Conference on Families in Minneapolis, Minnesota.

WILLIAM HALL, M.D., Columbus, was elected treasurer of the Ohio Division of the American College of Emergency Physicians. **GEORGE MILLAY, M.D.**, Columbus, was elected to the Board of Directors. Drs. Hall and Millay are emergency physicians at Riverside Methodist Hospital.

ERNEST W. HETRICK, M.D., Marion, was reelected chief of the Marion General Hospital medical staff. **FREDERICK G. WINEGARNER, M.D.**, Marion, was elected secretary-treasurer.

RICHARD MARTIN, M.D., Hamilton, director of pathology and the clinical laboratory at Fort Hamilton-Hughes Memorial Hospital Center, was awarded a grant of \$5,000 from the Fraternal Order of Eagles for cancer research. The grant will be used for equipment and supplies necessary to implement the cancer research at the hospital.

RAVINDER NATH, M.D., Youngstown, was elected president-elect of the Mahoning Valley Chapter of the American Diabetes Association.

LAWRENCE T. ODLAND, M.D., Hillsboro, was appointed to the Board of Governors of Highland District Hospital. Dr. Odland is the health commissioner for Highland, Pike, and Ross Counties.

RICHARD ORAHOOD, M.D., Marysville, was named chief of surgery at Memorial Hospital in Marysville. Dr. Orahoo has been a member of the hospital's staff since March.

MYRON PERLICH, M.D., Beachwood, was appointed assistant professor emeritus of medicine at Case Western Reserve University School of Medicine.

ROBERT SHAW, M.D., Columbus, received \$12,500 through Central Ohio Lung Association's annual fellowship program. The fellowship program encourages training of the recipients during the course of the year and also is a continued effort by the Lung Association in its research of pulmonary respiratory diseases.

WILLIAM E. SOVIK, M.D., Poland, was given the Distinguished Service Award by the Ohio Ophthalmological Society.

JIM STEPHENS, M.D., and **JEANNE STEPHENS, M.D.**, Oberlin, received Oberlin College's ninth Distinguished Community Service Award. They have been in their joint medical practice since 1937 and in Oberlin since 1942.

EDWARD L. VOKE, M.D., Akron, was inducted into Akron General Medical Center's Society of Distinguished Physicians. Dr. Voke was head of the radiology department for 21 years, served as chief of staff, initiated many programs in radiology and was active in community affairs.

EDWIN WESTBROOK, M.D., Warren, was elected president of the Trumbull County Branch Board of Eastern Ohio Chapter of the American Heart Association.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Karen S. Edwards

Meetings

Neurology for the Non-Neurologist; December 10-12; Sheraton Plaza Hotel, Chicago, Illinois; Sponsor: Rush Presbyterian-St. Luke's Medical Center; 20 credit hours, Category 1.

"Depression in the Elderly — Causes, Care, Consequences;" October 30-31; Clinic Inn, Cleveland, Ohio; Sponsor: The Center on Aging and Health, Case Western Reserve University and the Mid-Atlantic Regional Medical Education Centers of the Veterans Administration; fee: \$65. Contact: Center on Aging and Health, Allen Memorial Library Bldg., Room 101, Case Western Reserve University, Cleveland, Ohio 44106.

International Conference on Genetic Engineering; December 15-19; Sheraton Washington Hotel, Washington, D.C.; Sponsor: Battelle Memorial Institute. Contact: Battelle Conference Coordination Office, Suite 603, 331 Madison Ave., New York, N.Y. 10017 (212/490-3113).

Optometric bill withdrawn

The Ohio Optometric Association has withdrawn its support of HB 158, the bill which would allow optometrists to use drugs and diagnose disease without adequate training and clinical experience.

In a letter to House Representative Edward J. Orlett (D-Dayton), Allan D. Filakamp, the Ohio Optometric Association President said:

"Regrettably, over the last 18 months

of extended discussion and negotiation, for every concession we have made, the Ohio Ophthalmological Society and the Ohio State Medical Association have demanded two more, with no end in sight. Those demands, backed by the threat of yet another veto by Governor Rhodes, have converted this bill into one which our Association cannot, in good conscience, continue to support."

MISCELLANEA

• The AMA announces that the summer 1980 update to their Physicians' **Current Procedural Terminology** (CPT) now is available. This is the fourth update to the fourth edition of the publication which serves as a comprehensive system for naming, coding and reporting medical procedures and services. There are over 150 revisions in the summer update which include: new gastroenterologic procedures, pneumococcus immunization and extensive revision of otolaryngology surgical and medical procedures. CPT is available for \$12 each through the

Order Department OP-41, American Medical Association, P.O. Box 821, Monroe, Wisconsin 53566.

• Emergency physicians may be interested in a new book called **Public Relations in the Emergency Room**, published by the Robert J. Brady Co. The book, by Cyril T.M. Cameron, M.D., tells the physician how to deal with himself or herself in the emergency room, and how to handle their patients in an emergency situation. The book is available for \$14.95 from the publisher, Robert J. Brady Co., Bowie, Maryland 20715.

Putting a new bite on rabies

The Food and Drug Administration recently announced its approval of a safer, more effective vaccine against human rabies. The new vaccine, produced from viruses grown in cultures of human cells rather than duck eggs, provides immunity after just five injections in the arm instead of the currently required 16-23 injections in the abdomen.

The vaccine, Human Diploid Cell Rabies Vaccine (HDCV) will be distributed in Ohio through the State Health Department only, until large-scale commercial production becomes available. It currently is available in very limited quantity for

use in Ohio, and will remain in limited supply until the end of this year or the beginning of next year. It will be available, however, in cases of proven rabies exposure, or in cases of high potential exposure where the biting animal has escaped capture.

To obtain the new vaccine, contact George Bear, D.V.M., of the Division of Communicable Diseases at 614-466-4643 for instructions. For a complete, in-depth description of the product, refer to the June 13, 1980/Vol. 29/No. 23 **Morbidity and Mortality Weekly Report** publication from the Center for Disease Control.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Costly and unnecessary syphilis serology

By Thomas J. Halpin, M.D., M.P.H.

Many cases of syphilis have been counted since Sir William Osler's admonition "He who knows syphilis knows medicine." And even though this disease remains unchanged as a problem, some of its epidemiologic tenets have changed. Infection with syphilis was much more widespread at the beginning of the 20th century. Some studies estimate that one in every ten Americans around the time of World War I were infected, and probably this rate increased with war years. During World War II, 170,000 of 12 million servicemen called had to be treated for syphilis before they entered basic training. Because of this high infection rate, serologic tests for syphilis were the preeminent method of uncovering infections. However, since WW II, syphilis rates have fallen dramatically and even though they have increased since the late 1950s, the rates in the late 1970s still show a sixfold decrease over those during WW II. With such a decrease in disease prevalence, we have to take a close look at any mass screening programs.

Commonplace tool

The serologic test for syphilis has been such a commonplace tool that we simply accept it and rarely question its value as a public health case-finding method. However, in this era of cost-benefit concerns, the Ohio Department of Health decided to carefully evaluate the case yield from the syphilis serologic screening program (using 1979 data).

During 1979, 1,526,484 serologic tests for syphilis were performed. Only 1.9% or 29,149 positive tests were found. Even more striking is the fact that only 256 of these million and one half tests identified infectious syphilis cases. Primary and secondary cases accounted for 101 of the 256 cases identified. The 155 early latent cases are not as important because only about 25% of these will revert to the highly infectious secondary stage. This indicates that in excess of 5,000 tests must be performed before an infectious case is found. The remaining 28,000-plus positive results must be followed up by field investigators or clerical personnel. The vast majority of these noninfectious positives are elderly individuals uncovered by

hospital admission screening. A great deal of time and funds are wasted following up on these noninfectious cases.

Not without value

However, portions of the syphilis screening program are not without value. In 1979, the 101 primary and secondary syphilis cases found through screening represented 16.8% of the total number of primary and secondary cases reported (601). Almost one in five primary and secondary cases would not have been found without a screening program. The answer is not to totally dismantle the screening program but to refine it so that it is more cost efficient.

It is impossible to defend two of the largest screening categories, premarital serologies and hospital admission serologies. In 1979, from the 159,627 premarital serologies performed, only three primary or secondary cases of syphilis were found. Considering a cost of \$10 per applicant, it cost over \$500,000 to uncover each syphilis case. The total \$1.5 million to uncover these three cases is greater than the entire venereal disease control budget at the Ohio Department of Health. The premarital serology cannot be defended as a preventive measure since prenatal screening is a much better method to prevent congenital syphilis. In fact, the high risk syphilis areas are also the areas with the most illegitimate births, therefore, premarital screening is a particularly ineffective test to prevent congenital syphilis.

Routine testing

Even less useful than the premarital serology is the practice of requiring syphilis serologies for routine hospital admissions. Approximately 1 million hospital admission serologies were performed in Ohio during 1979. Only 20 primary and secondary cases of syphilis were found at a cost of approximately \$5 million or \$250,000 per case. Most of these hospital serologies were performed on the middle-aged and elderly; however, 97% of all infectious syphilis cases are found in individuals below the age of

50. Therefore, this is a particularly poor tool for finding infectious syphilis cases.

No need for large-scale screening

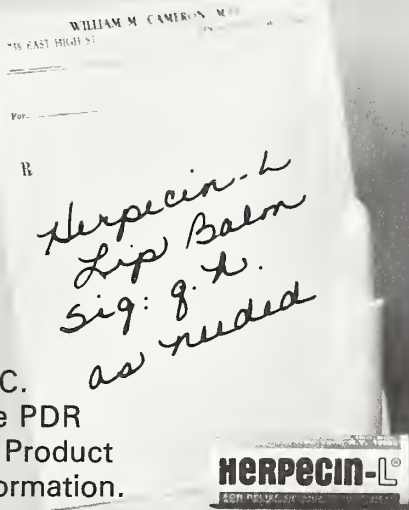
In addition, primary and secondary syphilis cases by definition have diagnosable signs and symptoms so there should be no need for large-scale screening. A proper physical examination coupled with an adequate history should uncover almost all these infectious syphilis cases. Therefore, there is no benefit for this \$5 million cost.

Routine syphilis screening for hospital admissions should cease immediately and only hospitalized patients with signs and symptoms of syphilis or with a history of contact should be tested for syphilis. In addition, careful consideration should be given to repeal of the premarital syphilis testing law.

Dr. Halpin, Columbus, is Chief of the Bureau of Preventive Medicine, The Ohio Department of Health.

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SECOND OPINION

Editor's Note

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

Dr. Mick is an internist, practicing in Findlay, Ohio

Generations of wind-up dolls

By Brooks A. Mick, M.D.

I've been sitting around with a little time on my hands and have been wondering, "What is wrong with the world?" That is, what is the one single big problem which, if solved, might allow the solution of all the other problems?

I might have come up with the answer. . .

I have considered many possibilities:

1. Are human beings, as a race, too stupid to be successful at managing a world? Fifty percent of the population is below average which is probably why "the majority is often wrong," but then, 50% is above average, so there are a lot of bright people left to solve problems and make discoveries.

2. Have governments so rewarded lack of success that they have stifled creativity and ambition? Possibly, but most people are not on welfare, do hold down jobs, and are working for their own idea of bettering their lot.

3. Is the government, at all levels, draining so much of the fruits of our labor that we lack capital or are growing discouraged? Not yet. Most of us simply look for ways to succeed in spite of the government, or we trick the government into helping us.

One could go on cataloging problems for a good many pages, and it is interesting how often government turns out to be a problem rather than a solution.

However, none of these seemed to me to be the ultimate problem.

My candidate for the ultimate problem is this: We seem to lack the ability to unlearn nontruths. We cling to outmoded beliefs and disproved assumptions with the tenacity of a barnacle on a ship's bottom. We resemble wind-up dolls, walking into the same wall 20 times until our springs run down. Then the next

generation begins the frantic nose bumping all over again, into the same wall.

The examples I am most familiar with relate to the practice of medicine, and one of the best of these is dietary therapy. Ulcers have been shown to heal just as well on a diet of spaghetti and pizza as on a bland diet or a diet of milk and cream. In fact, there is evidence that milk is harmful to ulcer patients to a minor extent. Yet I will bet at least 90% of ulcer patients are still placed on a bland diet or forced to drink milk and cream until nauseated.

In another example there is excellent evidence that diverticulosis is made worse or even caused by a lack of bulk in the diet; many patients, if not most, are nevertheless prescribed a low residue diet. Sort of the "hair of the dog," is it not?

In government and business we constantly see how special favors, safety regulations, etc., add to the ultimate cost of products, yet special interest groups keep begging for more intervention.

To find examples of harmful and conflicting government regulations, look at the automobile industry. In 1965, I could drive my old Corvair safely, comfortably, and economically, getting 26 miles per gallon. Now in 1980, the government wants to resurrect legislation for such economical automobiles. One might ask, "Where did those cars go and why?" However, a look at emission standards, heavy "safety" bumpers (which cost more to repair than the sheet metal they protect), and government-maintained, artificially low gasoline prices, which allowed and encouraged gas guzzlers, answers the question.

continued on page 555

must What you ~~should~~ know about the Ohio Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- A pharmacist who receives a prescription for a brand-name dangerous drug may dispense any generically equivalent drug of the brand-name dangerous drug prescribed if the drug to be dispensed has a lower, regular, and customarily retail price than the brand-name dangerous drug prescribed and if the practitioner has not written in his own handwriting "Dispense As Written" or "D.A.W." on the prescription, or when an oral prescription is given, has not expressly indicated that the prescription is to be dispensed as communicated.
- No physician, dentist, veterinarian, or person licensed to prescribe any drug shall be liable for civil damages or in any criminal prosecution arising from the incorrect substitution by a pharmacist of another drug for the prescribed brand-name drug.
- The failure of a physician, dentist, veterinarian, or other person licensed to prescribe a drug to write "Dispense As Written" or "D.A.W." on the prescription shall not constitute evidence of the prescriber's negligence unless the

prescriber had reasonable cause to believe that the health condition of the patient for whom the drug was intended warranted the prescription of a specific brand-name drug and no other. No licensed prescriber shall be liable for civil damages or in any criminal prosecution arising from the interchange of a generically equivalent drug for a prescribed brand-name dangerous drug by a pharmacist, unless the prescribed brand-name dangerous drug would have reasonably caused the same loss, damage, injury, or death.

R_x

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

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The 1980's Physician (Part II):

From patient advocate to health-care captain

By Karen S. Edwards

Editor's Note: This is the second article in a two-part series of interviews exploring the changing role of the 1980 physician, with OSU Marketing Professor Roger Blackwell, Ph.D. Last month, Dr. Blackwell said the 1980 physician will have to become as actively involved in the role of patient advocate, as he has traditionally been in patient care. This month, he outlines the role of the 1980 physician as captain of the health-care team, and tells how important the traditional role of patient care is to that responsibility.

OSMA JOURNAL: The future of medicine, then, is hanging on the brink and it's still uncertain which way it will go. Let's get Orwellian and assume that physicians haven't been listening, that they've been continuing to practice the traditional kind of medicine. What's going to happen?

ROGER D. BLACKWELL: If that were to happen, then I think the captain of the health care team in the future will be the organizational expert, and the physician would become like a lab technician today. The physicians would be brought in to do their specialized skills, but someone else is in charge of the whole thing.

JOURNAL: Should physicians be the captain?

BLACKWELL: There must be a captain — the question is whether it should be the physician or someone else. It might be far-fetched to think that the nurse-practitioner should be the captain of the team, but I'm not so sure that it is. I hear more and more people saying the "wellness coordinator" should be the captain. Since many physicians have not expressed a great deal of interest in being that, perhaps the wellness coordinator in our Orwellian future may be the one who prescribes the health care program. Perhaps it could even be a nutritionist. We look around today and see that there's no one now in that role. However, I'm not so sure that it's totally unbelievable that there will be somebody new in the future, who might say, "On those limited occasions when you're ill, I'll bring in a physician

to take care of you, but basically, I am your coordinator of health." That's on an individual basis. We might also see HEW or the FTC say, "We are responsible for the society's health. It is we who make the decision who lives and who dies, who gets health care and who doesn't. We need physicians as much as we need lab technicians, and when we designate them to do something, they will do it." Just as a lab technician doesn't initiate the procedure, but does it when it's requested.

While many people would see these scenarios as frightening and perhaps incredible, I raise them because I think it's important that we understand the societal efforts of these forces as they are occurring. What happens may not be determined exactly by what we want to do with patients, but what society will let us do with patients. I do feel, however, that the physician is best qualified to be the captain of the team.

JOURNAL: Why?

BLACKWELL: There are several reasons. One, they have far superior education and training. No one can question that— though it's possible we may find gaps in that education. I also believe that the physician has a system of morals and ethics which should give them more consideration. There has been this standard Hippocratic oath, or unwritten rules — seeing human life and the fight for it in a primary role. Other specialties are more technical and see technology rather than human life as dominant. Of course, to say that

physicians have this historic strength is not to deny that they might lose it. It's something so valuable it shouldn't be taken for granted. Physicians have historically said human life is something special. That gives them more of a right in our society to be the advocate for human life.

The third reason is that the economic situation has historically brought about the most qualified people to be physicians. It costs so terribly much to become a physician that only those with high perseverance, endurance, and intelligence have become physicians. However, with privilege has sometimes come abuse, and the surest way to dislodge the captain from the ship in a mutiny of patients and health care is for the physician to take too much reward for himself, and to fail to be responsible to the rest of the crew.

There's a temptation for physicians to say, "I deserve big homes, big cars — look how much I paid for my education." But that argument will only go so far with the population. If the physicians do not impose self-limitations on the reward structure, I'm afraid society will participate in a mutiny.

JOURNAL: Returning to your point that, "It costs so much to become a physician," are you saying that there is no such thing as a blue-collar doctor?

BLACKWELL: There are blue-collar doctors, but not unless they are awfully intelligent, awfully persevering. I would argue that a doctor who comes from a modest economic background probably has to have a lot more character, perseverance and intelligence than someone who comes from a higher economic group.

JOURNAL: Do you think blue-collar doctors need to be recruited — perhaps as more likely candidates for those small-town, rural areas in need of physicians?

BLACKWELL: That's an area that needs to be studied a lot more. However, I'm not so sure that the factory worker who becomes a doctor may not be just as attracted or more attracted to the high-income, financially rewarding specialties.

I do think one of the things we have to question is what is a complete medical education. We are developing

people who are very intelligent, who have the highest of technical skills. We must also make certain that we are attracting and training people who possess the highest character and morality in society — or some of the reasons why the physician should be captain of the ship may dissipate.

JOURNAL: What sort of attributes should medical schools be looking for in their candidates?

BLACKWELL: One is intelligence, and we measure that by admission tests and grades. Another would be creativity and problem solving. We want a physician who is able to solve a problem rather than just repeat the skills he has learned in the past. A third would be character and human values — a person who is going to take seriously the Hippocratic Oath.

JOURNAL: But how can you test those attributes in someone?

BLACKWELL: Their own expressions in their belief is *prima facie* evidence. It's a starting point. I think character recommendations are important and



Rebecca Doll

Dr. Blackwell

"Will physicians be specialists who are simply part of the team, brought in for their specialized skills, or will they, in fact, be the captain of the team?"

we should be more explicit as to why we want those recommendations. The danger, however, is anything can be taken to an extreme.

For example, I want a surgeon to operate on me. Do I want one with good technical skills or one with high character and the willingness to stand there and work to keep me alive? The answer is I want both. But I don't want a physician who's one or the other. If he's only the one with high technical skills, then I know I'm going to move into a medical system where that person does not have the right to be the captain of the ship. If he's something more than a technician, then he has a good chance of surviving as the captain of the medical team.

JOURNAL: What courses should medical schools be putting into their curriculum to keep up with the increasing changes in the profession?

BLACKWELL: Medical schools are going to have to deal with more training on interfaces with the environment. I doubt whether one could afford the luxury of a course in medical school dealing with

government regulations, but that could very well be a unit in a course which deals with the broader socioeconomic issues of medicine. The young physician, however, is unlikely to have as much influence on that socioeconomic system as the older, more successful physician. Perhaps the best way to teach the handling of the regulatory environment then is to teach the older physicians in continuing education types of programs — as is generally the way it's being done now by the AMA and the OSMA.

JOURNAL: What role will wellness or holistic medicine play in the future?

BLACKWELL: All new ideas come into existence in the society through what's known as the diffusion curve. The people who accept new ideas first are rather defined types. They're highly educated and tend to have certain personality traits which are more cosmopolitan. Holistic medicine conforms to the classic diffusion model, so that it's correct to say only a few people are really interested in it at the present time, and those people who are interested in it are predictable

types. It's not clear yet whether holistic medicine is a trend that will diffuse out widely among the population or be confined to a fairly small segment. Whichever way it curves, it's clear that the segment will become larger.

Perhaps if we take some of the best concepts of holistic medicine and apply them to the main stream, holistic medicine will never become a major phenomenon.

JOURNAL: Then you don't see it playing a large role in the future?

BLACKWELL: In terms of the purest holistic medicine, no. I think it's more likely their best ideas will be adopted in ways that have more mass application.

JOURNAL: In terms of the wellness theory, do you see physicians playing more of a role as health educators in the future rather than merely physicians who take care of the sick?

BLACKWELL: Yes. I'm not sure most physicians want that role, but it's another one of those cases that if they don't play the role, someone else will.

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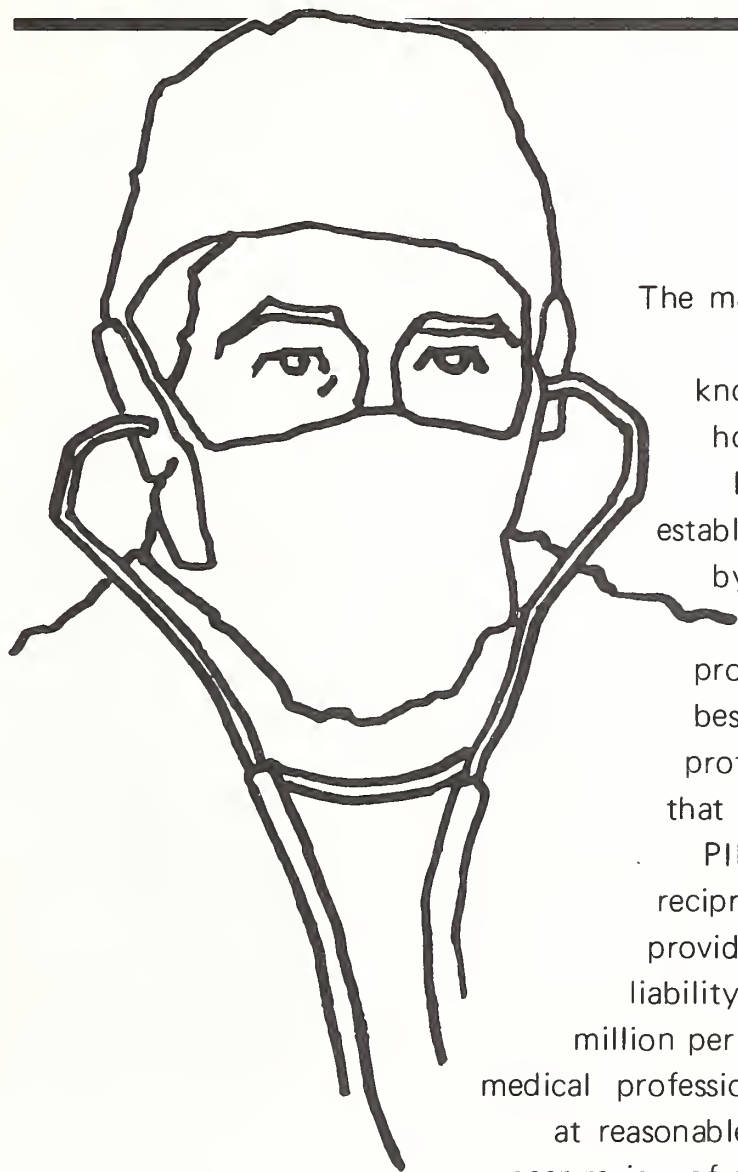
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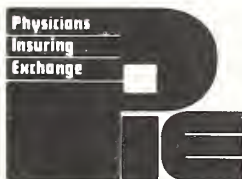
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Honor Behind the Lines

The 1980 Sports Medicine Awards

By Robert D. Clinger

Seven physicians were recipients of the 1980 Ohio Outstanding Team Physician Awards, presented recently in Canton, Ohio.

The awards, presented by the OSMA Joint Advisory Committee on Sports Medicine and the Ohio High School Athletic Association, honor physicians who:

- Have given at least 20 years of service as a team physician for Ohio high schools.
- Are endorsed by the physician's county medical society, district councilor or osteopathic academy.
- Are endorsed by school officials, coaches, trainers, civic officials, parents, fans or others in the physician's community.

This year's recipients are:

- Richard F. Slager, M.D. (honored with a Special Award for Outstanding Service to Sports Medicine in Ohio.)
- Richard L. Blackann, D.O.
- A. James Blanchard, M.D.
- A. R. Furnas, Jr., M.D.
- Myrl D. Musgrave, M.D. (posthumous)
- Thomas B. Shipley, M.D.
- John R. Sullivan, D.O.

Short profiles of those honored along with pictures taken at the award ceremony are featured on the following pages. To all of them, the *Journal* extends its congratulations.

Special award for outstanding service to sports medicine in Ohio

Richard F. Slager, M.D. Columbus

Innovative is the word most often used to describe Richard F. Slager, M.D.

A member of the OSMA-OHSAA Joint Advisory Committee on Sports Medicine since 1969, Dr. Slager served as its chairman from 1976 to 1978.

Examples of his innovative work for the committee include: the development of five subcommittees which allow members to concentrate on specialized areas of sports medicine activity; the involvement of the committee in audio-visual presentations on a variety of injury prevention and treatment topics; and service as the founding father and first chairman of the Subcommittee on Awards. It is therefore fitting that Dr. Slager, the founder of the Sports Medicine Award, a former Ohio State University quarterback, and a practicing orthopedic surgeon in Columbus should have been on the other side of the presentation this year. The *Journal* extends its congratulations to Dr. Slager.



Richard F. Slager, M.D.

**Richard L. Blackann, D.O.
Milan**

Dr. Blackann has served as team physician for Edison High School a total of 26 years, just 2 years short of the time he's spent in family practice at Berlin Heights, Ohio.

In recommending Dr. Blackann for the Ohio Outstanding Team Physician Award, Berlin-Milan Local School Superintendent, C. J. Lindecamp said, "He has become an institution in our community. It is difficult to imagine how any professional person, especially a physician, could donate the amount of time and effort, totally without compensation, that Dr. Blackann has donated to the young people in our schools."



A. James Blanchard, M.D.

**A. James Blanchard, M.D.
Toledo**

Dr. Blanchard has sandwiched 23 years as team physician for St. Francis DeSales High School between a busy practice as an ear, nose, and throat specialist, and providing physical examinations for the Central Catholic High School football squad, as well as the DeSales team.

Said St. Francis Athletic Director, Richard C. Mattingly of Dr. Blanchard, "It is always comforting to the coaches to know that a man of his qualifications and skill is on the sidelines to help in difficult situations. He always finds time to look after the needs of our team members."



Richard L. Blackann, D.O.

**A. R. Furnas, Jr., M.D.
Massillon**

Absent during just one game in his 23 years as team physician for the Washington High School football squad, Dr. Furnas, a general surgeon, also makes frequent trips to the team's practice site to check on injured players.

"His talent as a surgeon and his knowledge of sports medicine have enabled him to rehabilitate players from very serious injuries to play again — when I thought their playing days were over," said Mike Currence, Washington High School football coach.



A. R. Furnas, Jr., M.D.

"The experience of sharing in victories and defeats alike with many top flight young men as players, coaches and trainers has been one of the most satisfying, rewarding aspects of my life." — A. R. Furnas, Jr., M.D.

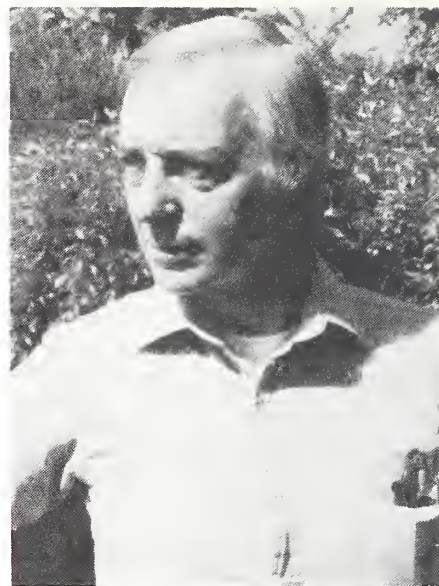


Myrl D. Musgrave, M.D.

Thomas B. Shipley, M.D. North Canton

Following in his father's footsteps (Dr. R. T. Shipley served as Canton McKinley team physician during the 1930s), Dr. Thomas Shipley can, himself, boast of 30 years of service as team physician for North Canton Hoover High School. A specialist in internal medicine, Dr. Shipley has also assisted with medical coverage of sectional, district, and regional basketball tournaments, and for the boys' state swimming meets in Canton.

"One of the most gratifying aspects of Dr. Shipley's service, loyalty, and dedication is that he is always at football practice. . .to check all of the bumps, bruises or other problems," said head football coach Donald R. Hertler.



John R. Sullivan, D.O.

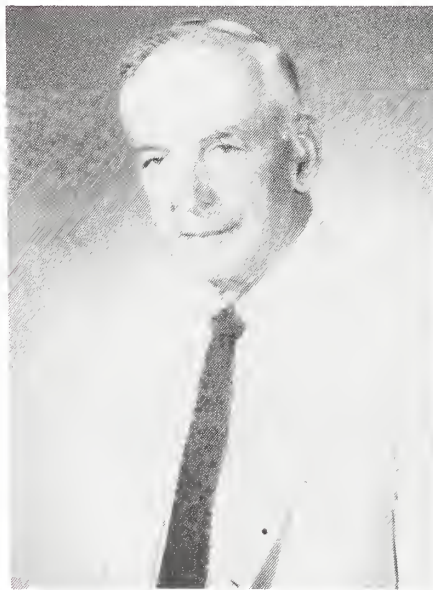
Myrl D. Musgrave, M.D. Canton

The late Dr. Musgrave served as Lincoln High School team physician from 1949 until illness caused him to retire in 1970. His death in 1971 was indeed a loss to sports medicine.

Said R. W. Gillman, vice president—public affairs, for Hoover Worldwide Corporation where Dr. Musgrave served years as company physician:

"He was truly a great physician who not only healed with his vast knowledge of medicine, but with his compassion and understanding of his fellow human beings."

In a letter of nomination on behalf of Dr. Musgrave, All Star Game Director Lou Venditti added, "In dealing with players and working with coaches, he has stressed kindness and true concern for our problems."



Thomas B. Shipley, M.D.

John R. Sullivan, D.O. South Charleston

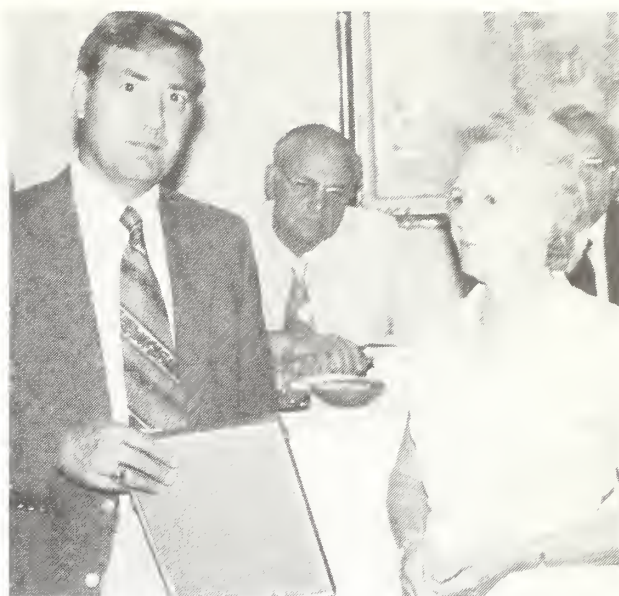
A family practitioner, Dr. Sullivan has not only served sideline duty for 20 years as team physician for Southeastern High School, but has helped the school solicit funds for a new stadium, helped construct the stadium, and worked in the concession stand during basketball season.

"Dr. Sullivan is an excellent physician, an excellent sideline physician, and has made great contributions to the Joint Advisory Committee on Sports Medicine," said Sol Maggied, M.D., himself a recipient of the Sports Medicine Award.

"A personal reward of mine was seeing two former St. Francis football players enter the private practice of medicine in Toledo, and take over last summer as team physicians." — A. James Blanchard, M.D.



A.R. Furnas, Jr., M.D., exchanges reminiscences with former Massillon football coach Earle Bruce, who now coaches the OSU Buckeyes.



Mrs. Myrl Musgrave accepts the award that was presented posthumously to her husband while former OSU Buckeye coach Woody Hayes looks on.



Richard F. Slager, M.D., steps forward to receive the Special Award for Outstanding Service to Sports Medicine in Ohio.

All photographs on this page were taken by Robert D. Clinger.

The Ohio State University
Center for Continuing Medical Education

announces

FOURTH ANNUAL HYPERTENSION SYMPOSIUM

Wednesday, October 8, 1980
Fawcett Center for Tomorrow
2400 Olentangy River Road
Columbus, Ohio

SPONSORED BY: The Ohio State University College of Medicine Center for Continuing Medical Education, and Departments of Pharmacology, Family Practice, Preventive Medicine, School of Nursing and The Ohio Department of Health

OBJECTIVES: This symposium will focus on diagnostic and treatment decisions in the management of primary hypertension. In the morning session, three guest faculty members will discuss the latest information on: the recently completed landmark study, the Hypertension Detection and Follow-Up Program, particularly as it concerns the treatment decisions for patients with mild hypertension; drug interactions in the treatment of hypertensive patients; and the role of protective lipids in hypertension. The afternoon session will focus on two areas of hypertension that warrant special attention: diagnostic decisions in hypertension and treatment decisions in the elderly hypertensive with discussion concerning the latest national task force report on Hypertension in the Elderly. These two topics will feature specialists in the related field, case presentations and discussions with audience participation. Participants may bring their aneroid sphygmomanometers for a calibration check. (This service is included in the cost of registration).

VISITING FACULTY:

- Walter M. Kirkendall, M.D., Professor and Head, Department of Medicine, University of Texas Medical School, Texas Medical Center, Houston, Texas
- Herbert G. Langford, M.D., Professor of Medicine and Physiology; Chief, Endocrinology and Hypertension Division, Department of Medicine, University of Mississippi Medical Center, Jackson, Mississippi
- Simeon Margolis, M.D., Ph.D. Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland
- William A. Pettinger, M.D., Professor of Pharmacology and Internal Medicine; Director of Clinical Pharmacology Division, University of Texas Health Science Center, Dallas, Texas
- Donald G. Vidt, M.D., Head, Clinical Section, Department of Hypertension and Nephrology, Cleveland Clinic, Cleveland, Ohio

THE OHIO STATE UNIVERSITY FACULTY:

- William H. Bay, M.D., Assistant Professor, Department of Medicine
- Joseph R. Bianchine, M.D., Ph.D., Professor and Chairman, Department of Pharmacology; Professor, Department of Medicine, College of Medicine
- David G. Cornwell, Ph.D., Professor and Chairman, Department of Physiological Chemistry; Associate Dean of Research, College of Medicine
- Martin D. Keller, M.D., Professor and Chairman, Department of Preventive Medicine; Assistant Professor, Department of Medicine
- Clifton J. Latiolais, Sc.D., Director of Pharmacy, University Hospitals; Professor, School of Pharmacy
- Albert H. Soloway, Ph.D., Dean, College of Pharmacy
- Mary F. Vaeth, M.D., M.S., Chief, Division of Chronic Diseases, Bureau of Preventive Medicine, Ohio Department of Health

CREDIT: As an organization accredited for continuing medical education, The Ohio State University College of Medicine Center for Continuing Medical Education certifies that this continuing medical education offering meets the criteria for 6 hours in Category I of the Physician's Recognition Award of the American Medical Association and the Ohio State Medical Association provided it is used and completed as designed.

Program is accepted for 6 prescribed hours by the American Academy of Family Physicians.
Nurses will receive 0.6 Continuing Education Units.

Pharmacists will receive 0.6 Continuing Education Units.

REGISTRATION: The registration fee of \$30 includes lunch, coffee and all educational materials. Send registration fee on your letterhead to:

Center for Continuing Medical Education, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, telephone 614/422-4985.

Physicians' Fees in Perspective

By Edward Zalta, M.D.

"While physicians' fees have risen 152% in the past 13 years, the federal budget has grown . . . 516% and the HEW budget a colossal 566%"

Viewed through the perspective of the past 13 years, and compared to the phenomenal increases in some sectors of the economy, physicians' fees have increased only slightly more than the overall inflation rate. The real bite out of the taxpayer's dollar has come from the enormous hike in the cost of government. While physicians' fees have risen 152% in the past 13 years, the federal budget has grown an unprecedented 516% and the HEW budget a colossal 566%. Overall inflation has hiked costs 130% in the same time period.

Attorneys' Fees

Until 1978, the Consumer Price Index (CPI) Detailed Report contained an index for legal services listed under "other goods and services." Although this reflected only the cost of writing a will, it nevertheless gave a comparison of the cost of legal services. Since then, this sole index of legal service has been dropped by the Bureau of Labor Statistics. Consequently, the index for attorneys fees in Table 1 was developed from personal interviews of attorneys in Los Angeles establishing 1967 as a base year. From this survey, the 1967 hourly wage averaged \$37 with the range being from \$25 to \$70; the 1980 average was \$110 with the range being from \$90 to \$175. The identical CPI formula was utilized in determining the percentage increase in attorneys' fees.

Government Indices

Data for the computation of percentage increases for the HEW budget, Social Security taxes, federal budget and cost of running Congress were obtained from the Library of

Congress, the *Budget in Brief*, published by the Bureau of the Budget.

Physicians' Services

Table 2 reveals that in the two years since my last comparison of selected indices (see *LACMA Bulletin* April 20, 1978), physician fee increases have lagged behind inflation. In 1978, inflation ran at an annual rate of 9.1% and physicians' services at an annual rate of 8.4%. In 1979, inflation increased 13.3%, compared to a 9.4% on the part of physicians. Physicians are to be commended for holding the line of fee increases, not only during the past two years, but for the entire period from 1967 to 1980.

Discussion

During the State of the Union Address, the President first attacked OPEC oil price increases, then American businessmen and American workers as the three villains in the inflationary crisis gripping our country. He is dealing in obfuscation because he failed to explain how Japan, a country which is totally dependent on imported oil, has an inflation rate of only 4.9%. Nor did he explain how wage and price increases (which are symptoms of inflation) cause inflation.

As Table 1 shows, government and government alone is the largest single cause of the inflationary spiral. Government spends more money than it takes in, and then issues new currency. This increases the number of dollars in circulation when the supply of dollars increases in relation to the supply of goods or services, then the price rises.

The increase in the federal debt has been horrendous, rising from \$209 billion in 1969 to \$892 billion in 1980.

This article has been reprinted with permission from the May 5, 1980 issue of the *LACMA Physician*.

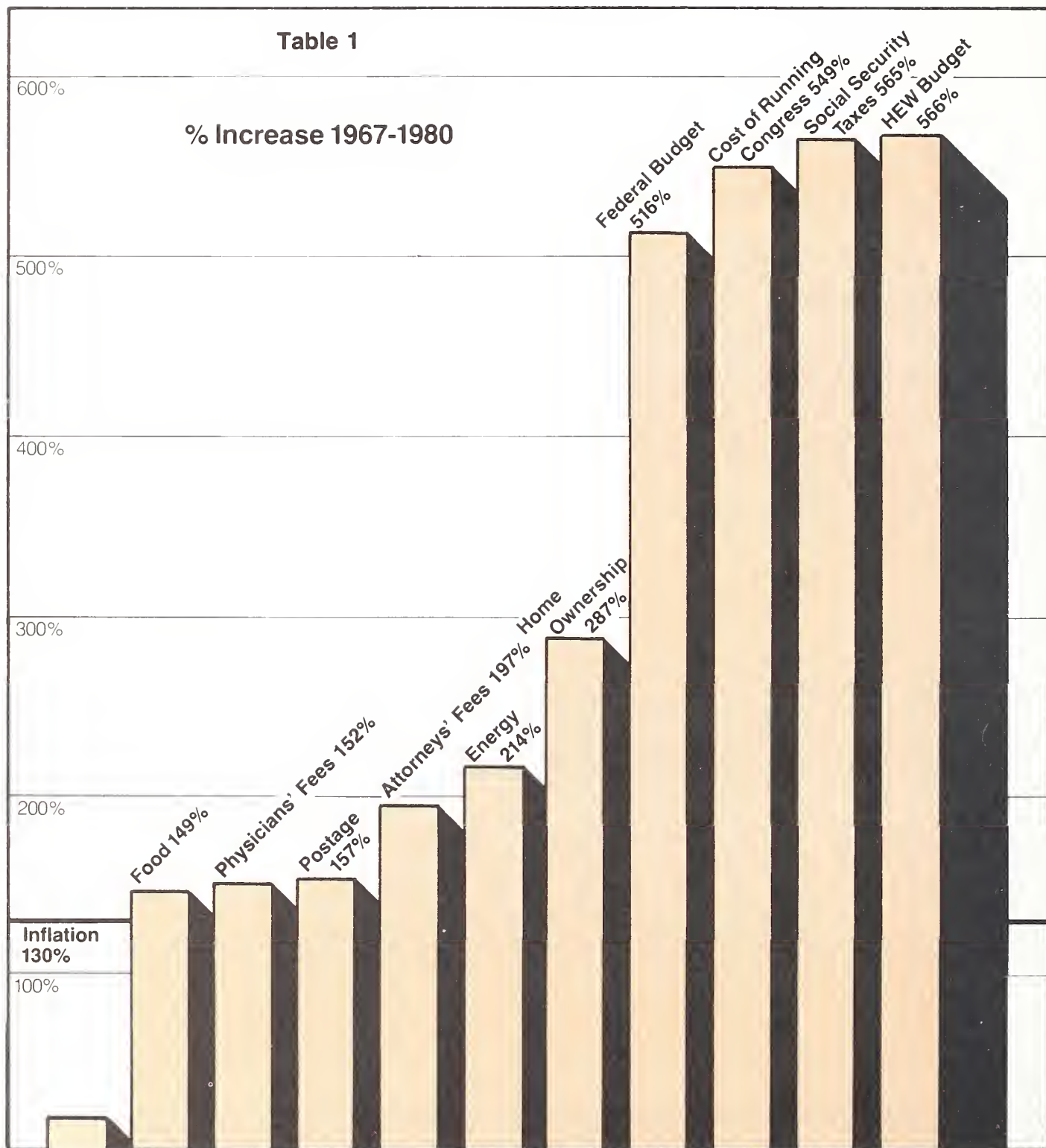
The largest increase, \$364 billion, was incurred during the first three years of the present incumbent's term — the same President who promised to balance the budget.

As government has the power to destroy our economic well-being through inflation, it also has the means to cure the disease. A massive tax cut combined with a dramatic and massive

reduction in federal spending (not just a balanced budget) is the remedy now needed.

It is my personal opinion that neither will come about, given the past failures

Table 1



of our elected officials to reduce their own inflationary spending in the running of Congress.

Limiting the funds available to our spendthrift politicians via the initiative process may well be our best means of attaining economic stability. The mood in the country is one of fiscal conservatism; in no way does it call for national bankruptcy through government-caused inflation.

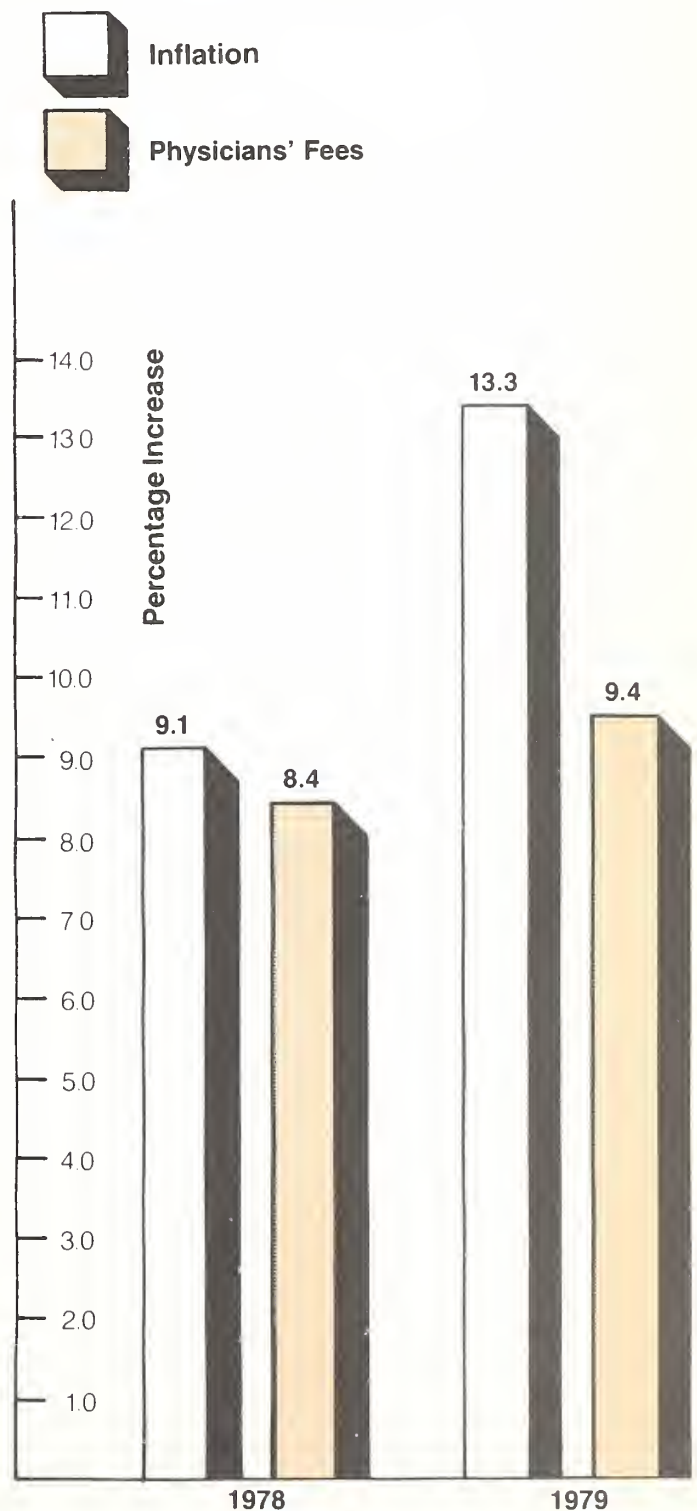
The percentage increases for food, physicians' fees, postage, energy, home ownership and inflation were obtained from the CPI Detailed Report Bureau of Labor Statistics, Department of Labor. These items use 1967 as the base year with the CPI indexed at 100. Computations of the percentage increase for each component were as standardized by the annual report as follows:

CPI	Index Point Change
Less Previous Index	230
Equals index point change	100
	130
Index Point Difference	Percent Change
Divided by previous index	130
Equals	100
	1.30
Results multiplied by 100	$1.30 \times 100 = \text{percentage change}$
Percentage change	130

Component	1967	1980	% Increase
Food	100	249	149%
Physicians' Fees	100	252	152%
Postage	100	257	157%
Attorneys' Fees	37	110	197%
Energy	100	314	214%
Home Ownership	100	387	287%
Federal Budget	100-billion	616-billion	516%
Cost of Running Congress	205-million	1.331-billion	549%
Social Security Taxes	24.3-billion	161.6-billion	565%
HEW	35-billion	233-billion	566%

Annual Percentage Increases in Physicians' Fees and Inflation 1978-1979

Table 2



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I can see other signs of this affliction in government and business and those directly involved can probably see many more.

How often do we recognize government meddling causing or even complicating a problem? Yet how often do we see the government stop its meddling? If a little meddling has caused a problem, will a lot of meddling solve it? That doesn't sound right, yet special interest groups continue to clamor for more intervention.

I am not saying that the goals are always undesirable. It just appears that governmental intervention is not the way to achieve these goals. Still the wind-up dolls keep walking into the wall.

Perhaps we in medicine can unlearn a few old nontruths and thereby set an example for those in government and business to follow. If a group with high intelligence can't get rid of its mental garbage, how can we expect others to do so?

Essentials of Clinical Cardiology. By Won R. Lee, M.D., Charles Press Publishers, \$24.95, soft-cover only.

This book is aimed primarily at the physician or student who wants to review clinical cardiology in a reasonably short period of time, such as is required in preparation for state and specialty board examinations.

The book presents up-to-date essentials on most subjects of clinical cardiology in a convenient outline form.

Commonly encountered electrocardiograms, vectorcardiographic patterns and echocardiograms are presented in the index for quick review of these subjects.

The book is available for \$24.95 per copy from The Charles Press Publishers, A Division of Robert J. Brady Co., Bowie, Maryland 20715.

Heartbook. By The American Heart Association, \$25.

This consumer-oriented guide, written by 31 experts in the field of cardiology, contains 370 pages of information covering every aspect of heart and blood vessel disease in infants, teenagers and adults. It also may be used as a guide to the prevention and understanding of treatment of cardiovascular disorders. The text is supplemented with 180 two-color drawings.

Royalties from books purchased directly from the Heart Association will be used to help the Association's continuing research, education, and community service programs.

The book may be obtained for \$25 per copy from local American Heart Associations.

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Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

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Death or divorce:

coping with the loss of a partner

By Pamela Jelly, R.N. and Eric C. Jelly, M.D.

"Give sorrow words. The grief that does not speak knits up the o'er wrought heart and bids it break." — William Shakespeare

"It (my divorce) has been a devastating experience. I've done it pretty much on my own — without counsel. The loneliness at times has been almost intolerable. I suppose I have at times resorted to drinking more alcohol, and I have just overwhelmed myself with busy work. It's always convenient to cop out with that. I work until the wee small hours and particularly at times when I know my efficiency is low. I do it to keep from going hysterical and then end up getting stone drunk."

This quotation, taken from an interview with a physician one year after separating from his wife, illustrates the despair experienced from a loss and emphasizes some of the ways that physicians cope with stress.

Loss is a complex and multifaceted experience, linked with very fundamental human issues. It is linked with the person's identity, their sense of omnipotence, and their desire for control — areas in which the physician is especially vulnerable. Physicians tend to rely heavily on their identity as caretaker, lifesaver, and healer and often find it hard to accept that they have not been able to save a marriage, or to heal a loved one. To quote

another physician who foresaw that divorce was the only solution to the family problem:

"I see myself as a helper, a physician, to be understanding.. how could I ever consider leaving them?"

In their personal experiences of divorce and death, physicians express feelings of helplessness related to their inability to control the situation beyond a certain point. Other physicians find it hard to accept the crisis that their colleague is experiencing, and there may be a withdrawal of support and a resultant loss of professional face for the stressed physician.

"I lost my old male friends when the marriage went down the tubes."

"People I thought were some of my dearest friends, and my wife's too, physicians here in town, have shunned us. When we needed the support the most we didn't have it."

These quotations illustrate that there is not only the loss of the marriage, but often loss of social contacts, close friends, professional colleagues, children, and even maybe a home and a way of life. For physicians — who tend to be people requiring a great deal of structure in their lives — the experience can be devastating.

Physicians often fear being seen as weak if they show their feelings. Even the seeking of counsel during times of stress is accompanied by thoughts of, "I should be able to sort this thing out myself."

The Normal Grieving Response

Grief is how people react to loss. To effectively grieve, it is essential for the individual to allow for time alone to feel the pain, to be in touch with resentment, be angry with the person who has left or perhaps not lived up to expectation, and also time to weep. It is important to recognize the fear of the inevitable changes ahead, and the options of having to cope alone or deal with a new close relationship. In the case of divorce, the inevitable question, "Will I repeat the same thing next time around," is always present.

Delayed grief is getting "stuck" somewhere in the grieving process. It can be a way of unconsciously holding onto the past — from facing the changes of the future.

LOSS & GRIEF — NEEDS

PRACTICAL NEEDS	GENERAL MAINTENANCE	EXTRA	IDEAL FOR PROBLEM- SOLVING
	WORK: OFFICE PATIENTS HOME: SHOPPING LAUNDRY GARBAGE <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> } X 2 </div>	LEGAL: ALIMONY CUSTODY OF CHILDREN BEQUESTS RELATIVES: CHILDREN:	
EMOTIONAL NEEDS	SADNESS GUILT ANGER LONELINESS LOSS OF CONFIDENCE	PAIN FEAR RELIEF HELPLESSNESS	IDEAL FOR RESOLUTION

Physicians share many traits which make them vulnerable to delayed grief reactions. One tendency is to cope by being "too strong," therefore, not recognizing or allowing for release of emotions. Another trait is the well-known mechanism of coping by staying so busy and having the days so structured that there is "no time" to grieve.

Caring for other members of the family before or instead of themselves is another well-intended trait of physicians which helps them stay in the process for a prolonged period of time. In the case of divorce, the continued contact with the original partner often for practical, economic, or legal reasons, serves to further delay the letting-go process, making it much harder to move forward.

Coping with Loss and Grief

There are particular problems to coping effectively with the death of a loved person or the death of a marriage. To effectively problem-solve, it is best to feel aware, alert, and optimistic. Those who have been

through this experience will know that it is inevitably associated with lassitude and some incapacitation. The needs that require attention can be grouped into two levels:

1. Practical or social needs.
2. Emotional and psychological needs.

Ideal coping is getting a balance of these two levels. If the emphasis on coping is kept at the practical level, there is a danger that the emotional level will not be dealt with. Similarly, by staying on the emotional level, many practical day-to-day requirements will not be met.

General maintenance tasks are often doubled after a loss. The everyday chores of living such as taking out the garbage, shopping, feeding the cat, working in the yard, and doing the laundry now have to be done by one person instead of two, and yet the full schedule of the medical office needs to be pursued. There may be increased financial burdens, missing incomes, and extra expenses such as attorneys to pay and perhaps two households to run. For the already busy physician,

the sudden increase can be overwhelming.

Holidays and vacations can be another stress with decisions to be made instead of just conforming to the usual pattern or ritual. Christmas shopping can become a burden instead of a pleasure. For parents, there is an added task of helping the children cope with their own individual reactions. (See related story.) It is no wonder that the self, the part of the person that needs care and nurturing at this time, can become neglected.

If the practical level is dealt with efficiently, friends and families may leave the scene, perceiving the physician as coping well when, in fact, they are most needed.

If the balance is in the other direction, however, deterioration of work and its subsequent ill effects on practice can occur. There is a danger for physicians to cope by excessively taking drugs or drinking alcohol.

Constructive Coping

To constructively cope with a loss:

1. Realize that grief takes time. There

is no way of grieving in a hurry — especially if remarriage is being considered. Giving sufficient time can lessen the likelihood of “ghosts” appearing in the next relationship.

2. Encourage active expression of feelings. If emotional aspects are not dealt with, they will inevitably creep up in some shape or form. They may appear as depression, psychosomatic symptoms or difficulties in new relationships.

3. Attend to personal needs. The grieving person needs plenty of rest and time alone. In the absence of a close, caring friend with whom the experience can be shared, professional support such as a minister or counselor should be obtained. If possible, find someone who has had a similar experience.

4. Do the essential practical things. Do only the necessary arrangements at home or the office. Don't make changes that are not essential in the early weeks or even months.

5. Cut down demands if necessary. Ask colleagues to assist with certain duties during the acute period, such as inpatient or on-call responsibilities.

6. Attend to spiritual needs. Seek appropriate religious support, such as

Children have three essential needs following a significant loss — consistency, support, and gender substitute.

Consistency is provided by keeping to the preexisting routine as much as possible. It is important to keep the same rules of behavior and not overcompensate for the loss by laxity of normal discipline.

Provide emotional support by recognizing that they too have had a loss. They need to be able to talk about this and be encouraged to express their feelings. The children need to keep reminders of the loved person, and be encouraged to remember significant anniversaries. In the case of divorce, it is important not to ask them to take

sides but keep them informed of legal progress with appropriate detail. Children need to attend the funeral of someone they have loved.

Young children who have a warm sympathetic substitute for the person of the same sex generally do better. Older children should be able to have some close contacts with people of both sexes.

Remember, however, there is a tendency for the child to idealize the absent parent, making both practical and emotional difficulties for the substitute person. If children are perceived to be stuck in the grieving process, or if their behavior is beyond normal limits, they too need professional help.

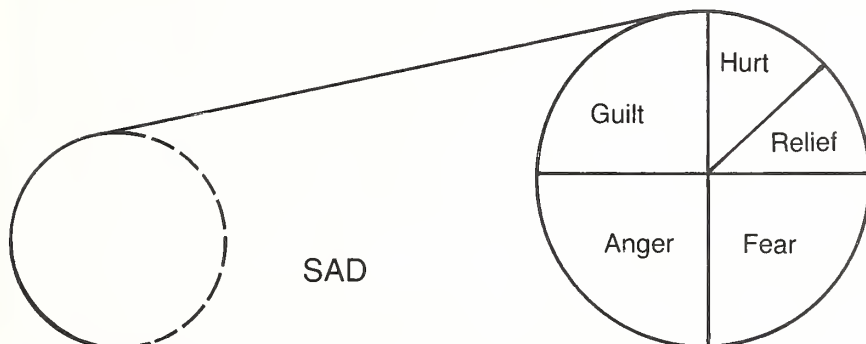
attending regular church services and functions.

7. Realize that you still have sexual needs. During the acute period, libido is likely to be decreased. Realize that sexual needs will return and it is not necessary to feel guilty about this.

8. Seek new associates or activities. The loss of marriage or a partner will

produce a void which eventually needs to be filled with new friends, hobbies, or activities. These will come in time but it helps to actively seek them as resolution takes place.

If the process of grieving is not successfully achieved, professional help should be sought. As with organic disease, preventive or anticipatory counseling will be easier and more effective at an early stage.



VARIES WITH A / CIRCUMSTANCES OF LOSS

B / RELATIONSHIP

C / INDIVIDUAL “FEELING STYLE”

D / TIME

Editor's Note:

Several weeks after this article was accepted for publication, Eric C. Jelly, M.D., died while on vacation with his wife and children in his native England.

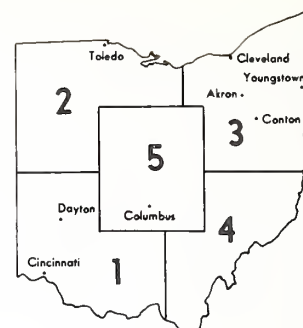
Dr. Jelly was director of the Family Practice Residency Program at Ohio State University, and he and his wife, Pamela, were partners in a research project studying the results of stress on physicians and medical students. From this research comes their article on “Death or divorce: coping with the loss of a partner.”

Mrs. Jelly, a clinical assistant professor at Ohio State University, intends to continue the research work which she and her husband were doing prior to his death.

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, **The Journal**, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of **The Journal**. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of **The Journal** for additional listings.)



SURGEON: Cardiovascular thoracic with general and transplantation surgery secondary specialty. Available July 1980. Desires suburban metropolitan or metropolitan community of 50,000 or more people. Interested in solo, small group or institutional practice and/or academic appointment. Has passed specialty board examination in general surgery; eligible in cardio-thoracic July 1980. Contact Box P-50 c/o Ohio State Medical Journal

UROLOGIST: Available July 1980. Interested in solo or group practice anywhere in Ohio. Eligible for specialty board examination May 1980. Contact Box P-53 c/o Ohio State Medical Journal.

INTERNIST: Available December 1979. Interested in solo or small group practice in community that is rural with metropolitan ties or suburban metropolitan with population of 15,000 to 500,000 anywhere in Ohio but area 4. Eligible for specialty board December 1979. Contact Box P-51 c/o Ohio State Medical Journal.

OBSTETRICIAN/GYNECOLOGIST: Available July 1980. Eligible for specialty board examination June 1980. Interested in solo or small group practice in a community that is rural with metropolitan ties, suburban metropolitan, or metropolitan with a population of 50,000 to 500,000. Prefers areas 1, 2 or 5. Contact Box P-56 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1980. Eligible for specialty board examination June 1980. Desires community of 100,000 or more people that is suburban metropolitan or metropolitan. Interested in group practice, part-time academic appointment with part-time practice, or institutional practice. Contact Box P-45 c/o Ohio State Medical Journal.

PEDIATRICIAN: Interested in small group practice in community of 15,000 to 100,000 people, rural with metropolitan ties or suburban metropolitan. Eligible for specialty board exam June 1979. Presently in military service; available July 1981. Contact Box P-67 c/o Ohio State Medical Journal.



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Medical Director

Donald L. Hanson
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Delegates' Report AMA Meeting, July 20-24, Chicago

by Oscar W. Clarke, M.D., Chairman and
Robert G. Thomas, M.D., Cochairman, Ohio Delegation, AMA

Editor's Note:

The following is a report of the important issues voted on by the Ohio AMA Delegation during the AMA Annual Meeting in Chicago.

The 1980 AMA Annual Meeting is now history. There were 76 reports and 132 resolutions acted on by the House of Delegates. Two of the resolutions were introduced by the Ohio Delegation at the direction of the Ohio House of Delegates:

1. Regionalization of Medical Services
2. CT Scanning

REGIONALIZATION OF MEDICAL SERVICES

The Ohio Delegation was successful in amending the reference committee report which considered this resolution. The final action adopted by the House puts the AMA in opposition to regulations which would, in effect, mandate the regionalization of medical service.

The Ohio Delegation was unanimous in support of this action.

CT SCANNING

The Delegation was also successful in changing the recommendation of the reference committee on this Ohio-sponsored resolution. The House adopted this Ohio resolution with two amendments by deletion. The resolved portion of the resolution is as follows:

"Resolved, That the AMA recommends that CT Scanning equipment should be readily available for patients; and be it further

Resolved, That efforts by Health System Agencies to block the acquisition of scanning equipment are deemed to be detrimental to the quality and cost effectiveness of health care; and be it further

Resolved, That a copy of this resolution be sent to each Health Systems Agency in the United States, the State Health Planning and Development Agencies, the State Health Coordinating Councils, and the Secretary of the United States Department of Health Services."

The Ohio Delegation was unanimous in support of this action.

There were several items of business which were felt to be of interest.

The following is a report on those actions.

1. PRINCIPLES OF MEDICAL ETHICS

The House adopted the proposed revision of the Principles of Medical Ethics that was developed by the Ad Hoc Committee on the Principles of Medical Ethics. The revised Principles follow this Report. This action required a two-thirds majority of the House in order to pass. The vote tally was 195 for with 186 being two thirds.

The Ohio Delegation was unanimous in voting against this action, feeling the changes were

more than minimal, as the Ohio House had directed.

2. OPPOSITION TO HCFA REGULATIONS ON REIMBURSEMENT OF HOSPITAL-BASED PHYSICIANS

The House adopted the following resolution:

"Resolved, That the American Medical Association continue to oppose the proposed uniform implementation of the Medicare regulations dealing with hospital-based physicians as set forth in the March 11 issue of the Federal Register (45 FR 15550)."

The Ohio Delegation voted unanimously in supporting this action.

3. REPEAL OF HEALTH PLANNING LAWS

The House reaffirmed action taken at the 1979 Annual Meeting calling on the AMA to stand committed to repeal P.L. 93-641 and P.L. 96-79; to urge all of its federated state medical associations to join in the effort; and that until such time as P.L. 93-641 and P.L. 96-79 are repealed, the AMA should encourage its members to participate as individuals, or as members of appropriate organizations and institutions, in health planning, and in presenting definitive proposals for

community and individual health, consistent with the law.

The Ohio Delegation was unanimous in support of the action.

4. **SUPPORT FOR LEGISLATION EXEMPTING LEARNED PROFESSIONS FROM RULINGS OF THE FTC**

The House adopted this report of the Board of Trustees which explains the Association's policy and actions to reaffirm the principle that a not-for-profit medical professional association (such as the AMA) is not within the jurisdiction of the Federal Trade Commission.

The Ohio Delegation was unanimous in its support of this action.

5. **HEALTH INSURANCE LEGISLATION**

The House adopted two reports of the Board of Trustees which detail Association activities concerning health insurance legislation following adoption of Resolution 62 (I-78). In addition, a resolution which asked the AMA to adopt the policy of opposition to a national compulsory catastrophic health insurance was referred to the Board of Trustees.

The Ohio Delegation was unanimous in support of these actions.

6. **REVIEW OF MECHANISMS FOR ACCREDITING MEDICAL EDUCATION**

The House adopted this report which sets forth the plan for the Board of Trustees to engage in formal discussions and negotiations with other organizations in regard to mechanisms for accrediting medical education, and to implement the results of the negotiations as soon as possible. **The Ohio Delegation voted support of this report.**

7. **PHYSICIAN COMPETENCE**

The House adopted this report dealing with the maintenance of competence by physicians. It states that mandatory recertification and continuing

medical education have not demonstrated that they assure high quality of performance of physicians. It further states the AMA should continue to encourage and assist in the improvement of voluntary continuing medical education, maintain peer review and develop better means of establishing data on patient care.

The Ohio Delegation supports this action.

8. **CURRENT TRENDS IN NURSING EDUCATION AND NURSE MANPOWER**

This report adopted by the House recommends that the AMA express to the National Council of State Boards of Nursing the concerns of medicine about the precipitous closing of hospital diploma schools of nursing before alternate programs have been established to provide an adequate supply of nurses prepared to meet the needs of hospitalized patients. Further, it recommends that the AMA continue to support hospital diploma programs, associate degree programs and baccalaureate programs as they exist today and to support those changes which would lead to an adequate supply of nurses providing good patient care. **The Ohio Delegation supports this action.**

9. **THE FIFTH PATHWAY**

This lengthy report of the Council on Medical Education is a study of the Fifth Pathway. The House referred the report to the Board of Trustees. **The Ohio Delegation voted for referral.**

10. **CATEGORIZATION OF HOSPITAL EMERGENCY CAPABILITIES**

This report dealt with specific guidelines for categorizing a hospital's emergency capability in eight critical care areas:
Acute Medical
Behavioral (psychiatric)
Burn
Cardiac
Neonatal, Perinatal and Pediatric

Poisoning/Drug
Spinal Cord
Trauma

Recommendations for OB/GYN emergencies are presented in a brief narrative format with the guidelines.

The House voted that the AMA's Commission on Emergency Medical Services distribute the Guidelines on Categorization of Hospital Emergency Capabilities as a **Draft** document for review and comment from interested organizations and report to the House at its 1981 Annual Meeting. **The Ohio Delegation supports this action.**

11. **JOINT COMMISSION ON ACCREDITATION OF HOSPITALS**

This report of the Board of Trustees acknowledged the widespread concerns with the accreditation process of the JCAH and describes the Board's initial and ongoing efforts to address these problems. The Board of Trustees will continue to analyze and reevaluate the AMA's relationship with the JCAH and will report to the House at its next meeting (I-80).

The Ohio Delegation was unanimous in its support of this action.

12. **PHYSICIAN SUPERVISED EXERCISE PROGRAMS AND REHABILITATION OF PATIENTS WITH CORONARY HEART DISEASE**

The House adopted (with revision) the report of the Council on Scientific Affairs which describes exercise programs in the rehabilitation of coronary artery disease patients, noting that such programs have led to objective and subjective rehabilitation of some patients and recommending that all programs be directed and supervised by physicians. **The Ohio Delegation was unanimous in support of this action.**

13. **AMA DUES**

The House of Delegates adopted

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the recommendation of the Board of Trustees that dues rates of \$250 for regular members, \$35 for residents, \$15 for medical students, and \$125 for members in their first year of practice be continued for fiscal year 1981. **The Ohio Delegation was unanimous in its support of this House action which continues the present dues rates.**

14. MEMBERSHIP TO THE STATE MEDICAL SOCIETIES

The Board of Trustees in this report, recommended, and the House approved, the encouragement of medical student involvement in organized medicine and urges that state and county societies remove any unnecessary initial requirements for membership. The report as approved, recommends that the dues burden for student members be in keeping with their limited resources to facilitate medical student participation. **The Ohio Delegation supported this action.**

15. PROFESSIONAL STANDARD REVIEW ORGANIZATIONS

The House of Delegates referred to the Board of Trustees a resolution which called for the strongest possible efforts by the AMA to seek repeal of the PSRO law and adopted a report of the Council on Medical Service endorsing the principle that hospital medical staffs continue to hold responsibility for the quality

of care and that PSRO should bring to the staff's attention any quality of care problems. The report further encourages PSROs to cooperate with existing CME courses and if interested, to develop programs that meet standards for accreditation. **The Ohio Delegation was unanimous in its support of these actions.**

16. STUDY OF HEALTH MAINTENANCE ORGANIZATIONS

The House of Delegates adopted this report dealing with an assessment of HMOs with respect to cost, quality and accessibility of care. The report analyzes the characteristics of 15 operating HMOs and reviews 20 years of research about prepaid health delivery systems. Removed from the report and referred to the Board of Trustees was a recommendation which stated "that the HMO approach to health care delivery be recognized as one which may result in care for enrollees at a lower total cost than for comparable groups in other health care delivery systems, whether the group, staff or IPA model is considered." **The Ohio Delegation vote on these actions was 8-1 in support of final House action.**

Additional House action on HMOs which had unanimous support of the Ohio Delegation, calls on the AMA to reaffirm its stand against special and

preferential subsidies to one form of health care and urges the federal government to stop giving grants and subsidies to HMOs.

17. DIRECT ELECTION OF AMA DELEGATES

The House of Delegates rejected this resolution which called for a study of the direct election of AMA Delegates by state and national specialty medical societies. **The Ohio Delegation supported this action.**

18. LIABILITY FOR EMERGENCY CARE TO AIRLINE PASSENGERS

The House adopted this resolution as follows: "Resolved, That the AMA endorse legislation that provides a "Good Samaritan Law" for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations." **The Ohio Delegation supported this action.**

As indicated above, there were many reports and resolutions, covering hundreds of pages, considered by the House of Delegates. A report of this kind does not do justice to the excellent reports developed by the AMA on a variety of subjects. If you would like to receive the full text of any of the reports in this summary or of any other action by the House of Delegates, please contact the OSMA office.

PRINCIPLES OF MEDICAL ETHICS

On Tuesday, July 22, 1980, the AMA House of Delegates adopted revised Principles of Medical Ethics - the first revision since 1957. The revised Principles were prepared by the Ad Hoc Committee on the Principles of Medical Ethics after two years of deliberation and input from all of organized medicine.

According to the chairman of the committee, "The Ad Hoc Committee, in trying to reach an appropriate stance between professional principles and social reality, wished to produce

standards, not rules. Standards that would maximize individual discretion and, at the same time, maximize individual accountability . . . Standards that would emphasize multiple responsibilities and right, (but) broad enough to withstand future changes in the professional society . . ."

Specifically, these principles are "seven positive statements . . . emphasizing the dedication to, and the primacy of, the patient, yet at the same time, recognizing social reality. They

emphasize individual, not collective, responsibility.

In presenting its report, the Ad Hoc Committee stated that these Principles:

- accurately reflect a proper contemporary ethical stance for the profession . . .
- are acceptable to a significant portion of the profession . . .
- conform to present legal requirements . . .
- are a firm foundation upon which further interpretations and

expansions can be built, and can withstand further changes within the profession and society . . .

- are strong and patient-oriented.

The exact wording of the newly adopted Principles of Medical Ethics follows.

NEWLY ADOPTED PRINCIPLES OF MEDICAL ETHICS

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients,

colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Next month in the *Journal*:

- "On record" interviews medical reporter Mary McGarey on physician image
- Health Planning in Ohio
- Urgent Care Centers, a look behind the scenes.

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Highlights of the 1980 AMA Annual Meeting

All photographs taken by Carol W. Mullinax, Assistant Director of Communications, Ohio State Medical Association.



Robert M. Smith, M.D., Toledo, attends one of the resolution committees.



The Ohio Delegation to the American Medical Association.



John E. Albers, M.D., Cincinnati, First District Councilor, addresses a resolutions committee.



OSMA President Robert Thomas, M.D. congratulates 1980 AMA Distinguished Service Award recipient Frank Mayfield, M.D., Cincinnati.



Dr. and Mrs. Frank Mayfield.

AMA Distinguished Service Award

The American Medical Association's 1980 Distinguished Service Award was presented to Frank H. Mayfield, M.D., Cincinnati, during ceremonies at the Annual meeting held in Chicago during July.

Dr. Mayfield, a neurosurgeon, was chosen for the honor by the AMA House of Delegates during the 1979 Interim Meeting in Honolulu.

A former president of the OSMA and former chairman of the Ohio Medical Political Action Committee, Dr. Mayfield was president of both the Society of Neurological Surgeons and the Harvey Cushing Society (American Assn. of Neurological Surgeons).

He received the American Board of Neurological Surgery's distinguished service award, and in 1977, he was the recipient of the Cushing Medal of the American Assn. of Neurological Surgeons.

The *Journal* extends its congratulations to Dr. Mayfield.

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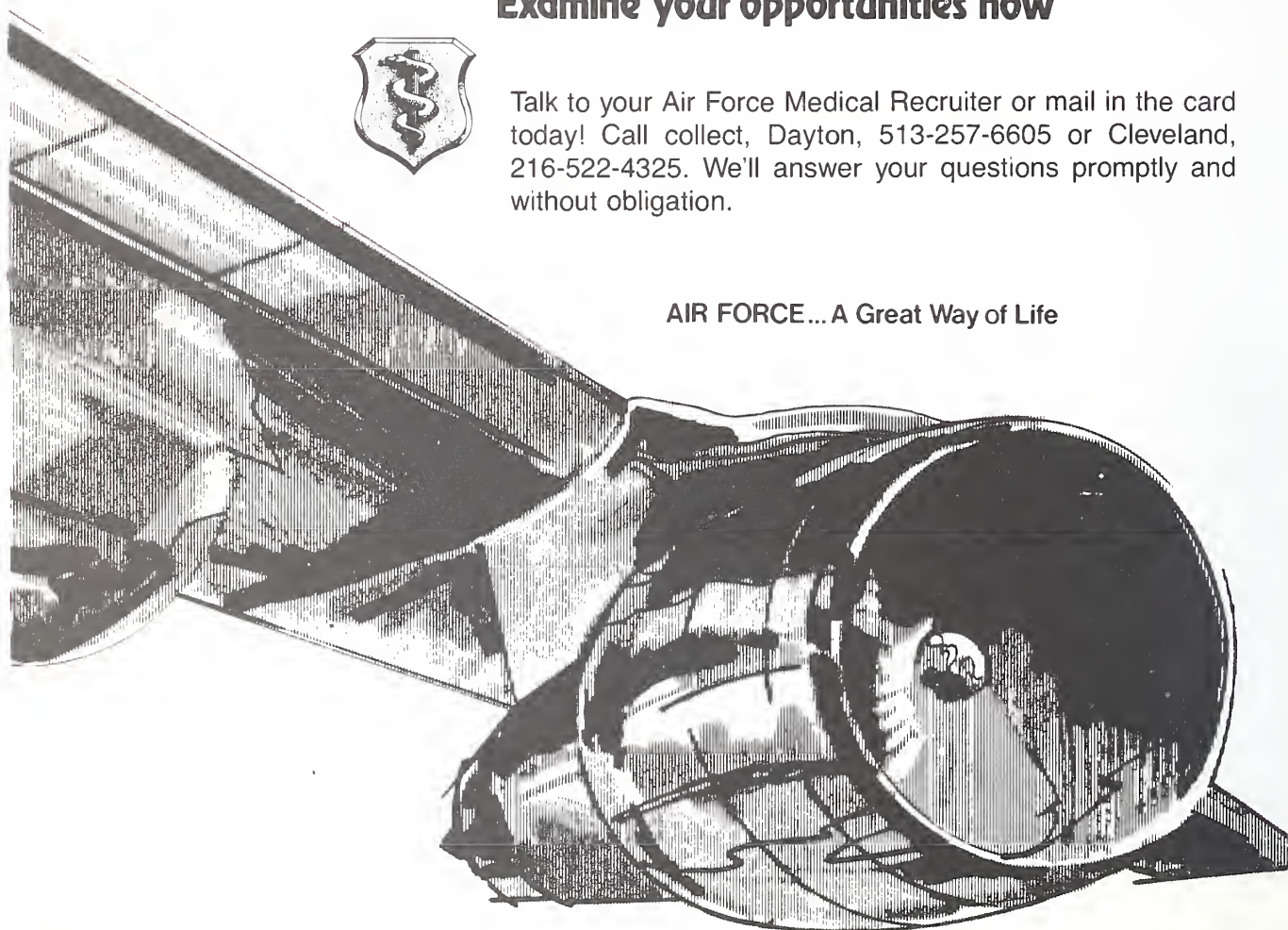
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PROCEEDINGS OF THE COUNCIL

July 12, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 12, 1980, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; David James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; W. J. Lewis, M.D., Dayton; John H. Ackerman, M.D., Columbus; and James E. Pohlman, Esq., Columbus.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Richard A. Ayish; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; and David W. Pennington.

The Council received, with regret, the resignation of J. Hutchison Williams, M.D., as Tenth District Councilor.

By unanimous vote, Dr. James Hickson, Mt. Gilead, was elected by the Council to fill the vacancy created by Dr. Williams' resignation and to serve until the next meeting of the House of Delegates.

ADMINISTRATION DEPARTMENT

Minutes of the April 12-13 and May 15, 1980 meetings of the Council *were approved*.

The minutes of the meeting of Council held by conference telephone call June 16, 1980 *were approved*.

Update Meeting — The Council selected November 16, 1980 as the date of the 1980 Update Meeting, the third of three trial meetings called for

under Resolution No. 3-78.

It was voted that OSMA delegates and alternates be invited in addition to those specified in the resolution.

The fall Councilor District meetings were discussed and the Councilors were advised to select dates for the fall sessions.

The Council voted to refer the subject of the "marketing of physicians' services" to the Communications Committee.

Mr. Page announced the appointment of Joseph Dusina as Computer Systems Coordinator.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Mrs. Wisse reported membership statistics.

Auditing and Appropriations

Committee — Dr. Ford presented the minutes of the July 11, 1980 meeting of the Committee on Auditing and Appropriations. Dr. Ford discussed the Coopers and Lybrand "Report on Examination of Financial Statements" as reviewed July 11 by Ben Minutilli of that organization.

The minutes *were approved*, with one amendment.

It was suggested that Mr. Minutilli be invited to meet with the Council for the presentation and discussion of the 1981 Financial Report.

Treasurer's Report — Dr. Barr presented the Report of the Treasurer.

The report was filed.

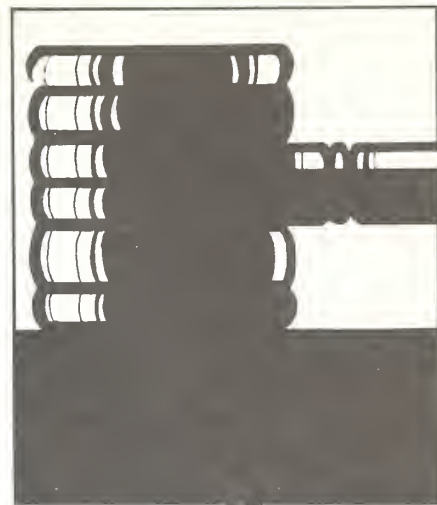
DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Emergency and

Disaster Medical Care — The minutes of the July 9, 1980 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Torrens and the minutes were filed.

1980 House Resolutions — The resolutions of the 1980 House of Delegates were taken up by the Council.

The resolutions were assigned, in accordance with the staff working draft, by consent calendar, with the calendar open until the September meeting for consideration of the



council proceedings

recommendations on any of the resolutions.

Resolution No. 19-80 was removed from the calendar for discussion in September, at the request of Dr. Kilroy.

Ad Hoc Task Force to Study Leadership Conferences, Interim Sessions, and District Conferences — An Ad Hoc Task Force to Study Leadership Conferences, Interim Sessions, and District Conferences *was approved*, and Dr. Thomas appointed the following to serve on this committee: Stewart B. Dunsker, M.D., Cincinnati, Chairman; J. Foster Boyd, M.D., Wilmington; A. Robert Davies, M.D., Dayton; Philip T. Doughten, M.D., New Philadelphia; Richard J. Nowak, M.D., Cleveland; and Joseph Sudimack, Jr., M.D., Warren.

Ohio State Medical Board CME Program — A staff review of the Ohio State Medical Board CME Program was discussed and was referred to the Committee on Education, with the instruction that any policy matters be returned to Council for its consideration.

CME Survey Proposal — A proposal for a survey of Ohio physicians on their attitudes regarding Continuing Medical Education was presented by Dr. Spragg.

The Council voted *not* to fund this particular survey. The idea or concept of the survey was referred back to the Committee for further study.

DEPARTMENT OF GOVERNMENT RELATIONS

Health Planning — Mr. Pennington discussed Health Planning developments in Ohio.

Mr. Pennington was commended for his work in this area.

The Council voted to ask the Committee on Government Relations to deal with appropriateness review problems.

Mr. Gillen reviewed development in Medicaid, Medicare, and medical insurance plans.

DEPARTMENT OF ORGANIZATION SERVICES

JUA Statistics — Statistics on the Joint Underwriting Authority were reviewed by Mr. Mulgrew.

PICO — Dr. Thomas reported on several developments regarding Physicians Insurance Company of Ohio.

American Medical Association — Dr. Clarke reviewed the schedule for the AMA Interim Session July 20-24.

Dr. Lewis reviewed an AMA Board of Trustees Report on Continuing Medical Education.

DEPARTMENT OF HEALTH EDUCATION

Subcommittee on Impaired Physicians — The minutes of the June 1, 1980 meeting of the Subcommittee on Impaired Physicians were reviewed by Mr. Clinger. The report was filed.

Needy Physicians — The Council voted to support the principle of creating a fund at the AMA with regard to assistance for needy physicians.

OSMA/ONA Liaison Committee — The minutes of the OSMA/ONA Liaison Committee meeting of May 29, 1980 were presented by Mr. Clinger and were filed.

Committee on Mental Health — The Council suggested to the Committee on Mental Health that the Committee urge the consideration of programs for additional long-term psychiatric care of chronically ill patients.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Federal Legislative Update — Mr. Mulgrew reviewed Federal legislation. The Gephardt-Stockman bill to deregulate the health care industry was discussed as a significant new approach in the national health care debate.

State Legislation — A current data sheet on State legislation was discussed and 19 current bills were reviewed.

Prisons and Jails Program — Mr. Ayish reported on the Prisons and Jails Program of the OSMA involving 20 jails in the Ohio area.

The Council voted to thank Michael Zellers for his service as Coordinator of the Prisons and Jails Project and to wish him well in the practice of law in Cleveland.

The Council voted to delegate to the officers the policy issue involving the composition of the Ohio State Medical Board.

A letter from Dr. Richard Budde, President of the Academy of Medicine of Greater Cincinnati, was referred to the Department of State and Federal Legislation.

COMMITTEE ON COMMUNICATIONS

Ms. Doll presented the minutes of the July 2 meeting of the Committee on Communications.

The minutes were filed.

The Executive Director commended the editor of *Synergy* on another outstanding issue.

FIELD SERVICE DEPARTMENT

Mr. Holcomb reported on a request from National Health Service Corps to work with the Corps on encouraging participation by Ohio medical residents.

There were no objections to Mr. Holcomb's complying with the request.

Mr. Holcomb discussed physician placement and the probability of the necessity to expand this service by OSMA. Mr. Holcomb was instructed to assemble concepts for consideration of the Auditing and Appropriations Committee.

CONSTITUTION AND BYLAWS AMENDMENTS

The proposed amendments to the Code of Regulations of the Academy of Medicine of Columbus and Franklin County were approved as submitted.

The proposed amendments to the Constitution and Bylaws of the Mahoning County Medical Society were approved as resubmitted.

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

OHIO DIRECTOR OF HEALTH

Dr. John H. Ackerman, Ohio Director of Health, addressed the Council.

He asked alertness regarding occurrence of encephalitis and Rocky Mountain Spotted Fever.

He announced plans to reimmunize those children who were immunized for measles prior to age one.

The Council suggested Dr. Albert A. Brust, Dayton, as the OSMA representative on the Ohio Hypertension Coordinating Council.

There being no further business, the meeting was adjourned.

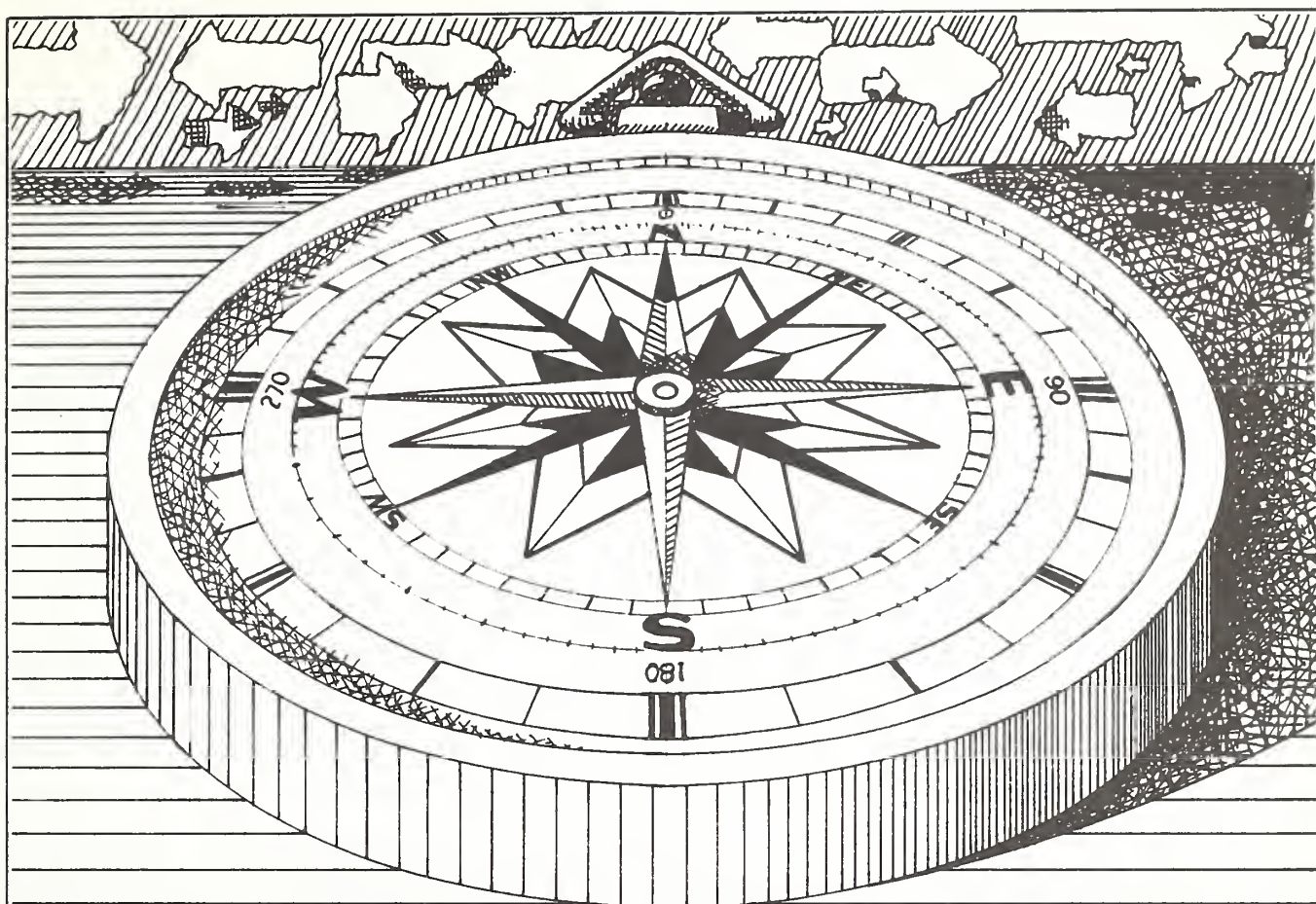
ATTEST: Hart F. Page, CAE
Executive Director

FDA recommends no refill on Darvon

The Food and Drug Administration, citing deaths due to overuse and abuse, recommended that doctors not allow their patients to get refills of the controversial pain killer most often sold as Darvon.

Currently, prescriptions for the drug — known generically as propoxyphene — may be refilled five times every six months, unless the prescribing doctor specifies there are to be no refills.

The FDA, in a notice sent to the nation's health professionals, advised doctors to specify "no refill" on all prescriptions, and to put it in writing rather than calling in the order. Compliance will be voluntary.



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Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

Obituaries

WALTER B. DEVINE, M.D., Zanesville; Ohio State University College of Medicine, 1936; age 69; died June 15; member OSMA and AMA.

CLARK FITZMORRIS, M.D., Cincinnati; University of Colorado School of Medicine, Denver, 1928; age 82; died July 19; member OSMA and AMA.

PAULINE B. FREEMAN, M.D., Danville; Ohio State University College of Medicine, 1933; age 74; died July 1; member OSMA and AMA.

LEONARD J. HAAS, M.D., Cleveland; St. Louis University School of Medicine, 1937; age 69; died July 11; member OSMA and AMA.

CLARENCE HULLINGER, M.D., Springfield; Ohio State University College of Medicine, 1930; age 74; died July 6; member OSMA and AMA.

EARL F. LIMBACH, M.D., Massillon; University of Maryland School of Medicine, Baltimore, 1928; age 79; died July 23; member OSMA and AMA.

C. W. LIGHTHIZER, M.D., Steubenville; Jefferson Medical College of Thomas Jefferson University, 1928; age 80; died July 2; member OSMA and AMA.

KENT EDWIN MARTIN, M.D., Sun City, Arizona; University of Cincinnati College of Medicine, 1932; age 77; died July 30; member OSMA and AMA.

MARCUS C. MILLER, M.D., Cairo; Ohio State University College of Medicine, 1921; age 86; died April 19; member OSMA and AMA.

JOHN ROBBY, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1926; age 87; died July 11; member OSMA and AMA.

WILLIAM J. RUCKER, M.D., Painesville; Meharry Medical College School of Medicine, Nashville, 1929; age 82; died June 25; member OSMA and AMA.

ROBERT H. SCHOENE, M.D., Columbus; Ohio State University College of Medicine, 1935; age 72; died July 8.

ROBERT J. WILLIAMS, M.D., Salisbury, N.C.; age 74; died June 29.

HAROLD C. ZIEGLER, M.D., Hartville; Ohio State University College of Medicine, 1938; age 69; died June 6; member OSMA.

JOSEPH C. AMERSBACH, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, 1927; age 78; died July 8; member OSMA and AMA.

AUBREY E. BOYLES, M.D., Mt. Prospect, Illinois; Northwestern University Medical School, Chicago, Illinois, 1930; age 75; died July 25; member OSMA and AMA.

LOUIE C. COSGROVE, JR., M.D., Swanton; Georgetown University Medical School, 1934; age 73; died July 8.

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November

TOPICS IN GASTROENTEROLOGY: November 19-20: Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland; 12 credit hours; fee: \$120, \$60 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, phone: 216/444-5696.

11TH ANNUAL CARDIOLOGY SYMPOSIUM-MYOCARDIAL INFARCTION: November 5: Daytonian at Courthouse Square, 4th & Ludlow St., Dayton; sponsor: Wright State University School of Medicine; cosponsors: Kettering Medical Center and Miami Valley Chapter of American Heart Assn.; 7 credit hours; fee: \$75 for Wright State faculty, \$100 others; contact: Ms. Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

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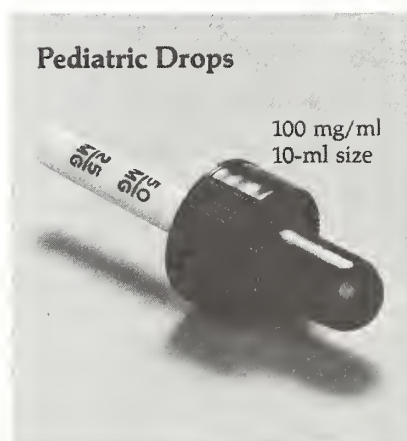
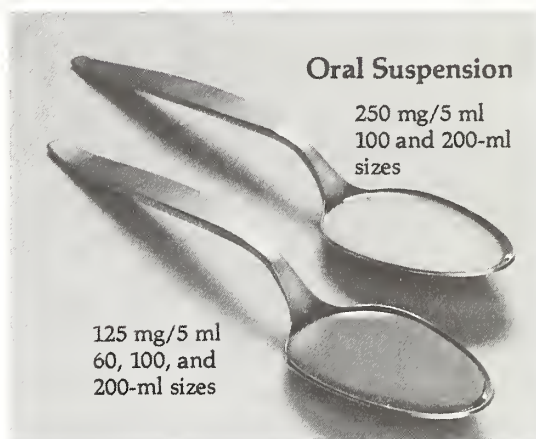
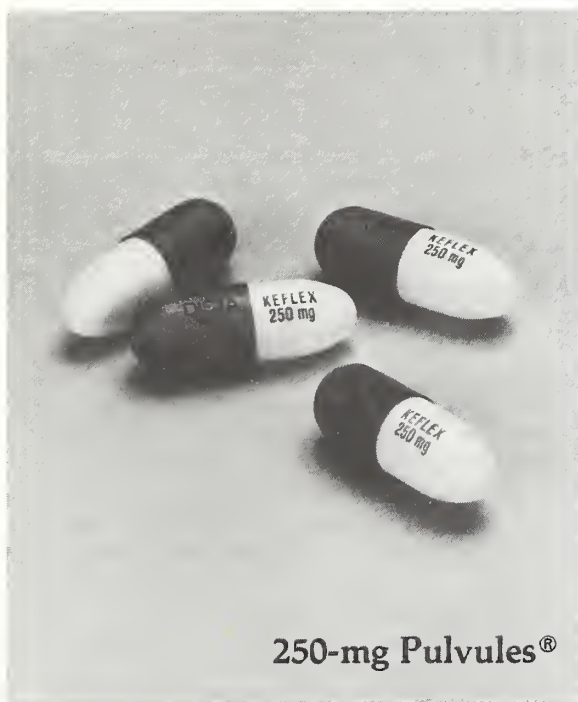
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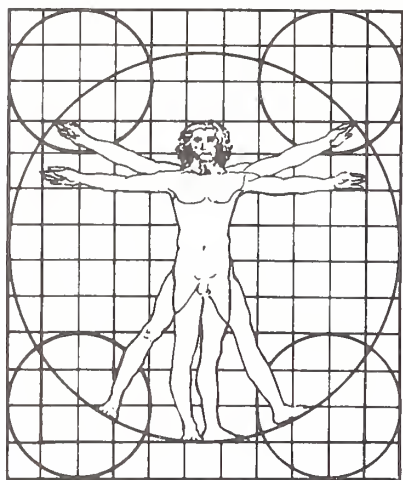


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CLINICAL & SCIENTIFIC

Medical Hyperbaric Oxygen Therapy: 22 Cases

Frank Welsh, M.D.
Luis Matos, M.D.

Twenty-two patients had hyperbaric oxygen therapy at an Air Force medical center between 1976 and 1979. Eighteen patients benefited and four did not. One of two carbon monoxide poisoning patients, both gas gangrene patients, and four of five osteomyelitis victims were greatly helped. Eleven of 13 soft tissue wounds were treated with hyperbaric oxygen. This local series exemplifies the range and limitations of the medical application of hyperbaric oxygen.

*Medical hyperbaric oxygen therapy
Hyperbaric oxygen therapy
High pressure oxygen treatments
Gas gangrene
Carbon monoxide poisoning*

A REVIEW OF 22 PATIENTS treated at Wright-Patterson Air Force Base Medical Center, Ohio, from 1976 to 1979, illustrates the utility of hyperbaric oxygen therapy (HBO) in treating a variety of hypoxic conditions. While hyperbaric air therapy has long been used to treat decompression sickness, the addition of 100% pure oxygen, breathed through a mask, is thought to greatly enhance its therapeutic potential. We have been successful in using HBO to treat carbon monoxide poisoning, gas gangrene, chronic bone infections, and soft tissue defects.^{1,2} HBO, used to promote jaw bone healing following oral surgical procedures, will be the subject of another report from this medical facility.

Carbon Monoxide Poisoning

Carbon monoxide (CO) is the most common type of poisoning reported. About half of fatal poisonings in the United States are caused by CO. The condition is not identified readily because the symptoms are similar to those of many common diseases—nausea, headaches or back and neck stiffness, muscular weakness, and confusion.

Because CO has a 200-fold greater affinity for hemoglobin than does oxygen, prolonged exposure to even

small concentrations (partial pressures) of CO can cause hypoxia and neurologic damage. There are three mechanisms of CO toxicity. Carbon monoxide (1) blocks hemoglobin transfer of oxygen; (2) shifts the oxygen dissociation curve to the left; and (3) combines with cytochrome oxidase A3 and disrupts intracellular respiration.

With hyperbaric oxygen, CO is eliminated more rapidly from hemoglobin and also from cytochrome oxidase A3. With fresh air breathing, the half time for elimination of CO is 5 hours and 20 minutes. With 100% oxygen, it is 40 to 80 minutes, and with 100% oxygen at three atmospheres the half time elimination of CO is reduced to only 23 minutes.³ At this depth the patient also will have 6.4% volume of oxygen physically dissolved in the plasma which is available immediately to the tissues. This is enough to support metabolism even in the absence of functioning hemoglobin. By hastening the displacement of CO, HBO assists in correcting cerebral edema and lessens the neurologic insult from hypoxia.

Hyperbaric oxygen therapy should be used when levels of carboxyhemoglobin are higher than 25%, if the patient shows neurologic signs, or if the EKG shows a depressed ST segment.

Gas Gangrene

Gas gangrene results from anaerobic clostridial proliferation in ischemic tissues. Symptoms include acute

Dr. Welsh, formerly Assistant Clinical Professor of Surgery, Wright State University School of Medicine, Dayton, is currently in private practice of aesthetic plastic surgery in Cincinnati and on the active staff of Bethesda Hospitals. Dr. Matos, Gretna, La., Resident in Aerospace Medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas. Reprint requests to Dr. Welsh, 10496 Montgomery Rd., Cincinnati, Ohio 45242.

The observations and opinions expressed herein are wholly those of the authors and in no way reflect the policy of the Department of the Air Force or the Department of Defense.

Submitted December 5, 1979.

onset of pain in affected part out of proportion to the degree of injury, swelling, pale overlying skin with bronze discoloration developing later, low-grade fever, obtunded sensorium, and crepitus. The toxin is tissue-fixed and detoxified so that the progression of gas gangrene is dependent upon continued production of the alpha toxin by the clostridial organism. Hyperbaric oxygen at moderate pressures stops toxin production and is bactericidal at higher pressures.^{4,5}

Breathing 100% oxygen at a pressure of three atmospheres establishes a pO_2 of 2,280 mmHg. A pO_2 of 250 mmHg stops alpha toxin production by the organism and a pO_2 of 1,520 mmHg is bactericidal for *Clostridium perfringens*. Thus, spread of the infection is curtailed, potentially necrotic tissues are spared, and systemic toxicity is controlled. HBO reduces the need for radical surgical debridement and may save limbs as well. However, surgery and antibiotic therapy remain the cornerstones of infections caused by anaerobic clostridial organisms.

Osteomyelitis

Hypoxia in ischemic bone interferes with normal healing. Bone infection persists and osteogenesis is retarded until vascularity of the infected area can catch up with cellularity. HBO stimulates granulation tissue, neovascularization, and osteoneogenesis in these hypoxic bone lesions.

Soft Tissue Defects

An actively healing wound requires far more oxygen than resting, healthy connective tissue, but the detrimental effect of the injury on local circulation makes the oxygen supply least when tissue demand is the greatest. Oxygen accelerates wound healing by stimulating fibroblast mitosis and migration, epithelialization, and collagen synthesis.

Oxygen is particularly critical to collagen synthesis as it may be the rate-limiting substrate for two steps in collagen synthesis. First, oxygen is used to produce adenosine triphosphate (ATP) and several ATP molecules are needed to insert each amino acid into the collagen molecular chain. Also, oxygen is a substrate for the hydroxylation of proline and lysine along the collagen molecule. This step is crucial for the excretion of collagen from the fibroblast and hydroxylysine is the site of cross-linking in collagen chains. This cross-linking gives collagen its strength and forms the stable scar of a well-healed wound.

Method

While in a chamber filled with air at two or three times normal atmospheric pressure, the patient breathes 100% oxygen via an aviator's mask. After hemoglobin is saturated, additional oxygen is carried dissolved in the plasma. Although the amount of dissolved oxygen is not great due to its low solubility, oxygen diffuses readily.

Thus the driving force of increased oxygen pressure delivered to the lungs is easily transmitted to the tissues.

Limitations and Contraindications

Limitations of HBO include toxic effects on the central nervous system and lungs along with most other organ systems. Retinal damage, erythrocyte hemolysis, myocardial damage, and hepatic functional impairment have been reported. Convulsions occur with increasing frequency when 100% oxygen is breathed at greater and greater depths. Pulmonary edema, hemorrhage, and respiratory failure result from prolonged, uninterrupted oxygen breathing even at moderately increased partial pressures of oxygen. For this reason, interludes of air breathing are provided every 15 to 20 minutes during treatment dives in a chamber.

Clinically significant chronic obstructive pulmonary disease, pneumothorax, pulmonary bullae, known malignancy or metastatic disease, history of optic neuritis, viremia, and claustrophobia contraindicate the use of HBO.

Patient Evaluation

Patients reviewed by the author include two cases of carbon monoxide poisoning, two cases of gas gangrene, five cases of osteomyelitis, and 13 cases of soft tissue wound healing defects. Eighteen patients were benefited by HBO and four patients ultimately were not helped. (See Table.)

A comatose CO-poisoned patient (Case 1) was treated 33 hours after exposure, too late to reverse the severe neurologic damage. The second CO-intoxicated patient (Case 6) was only mildly impaired, but showed considerable clearing of mentation after a single dive.

The two gas gangrene patients both survived and healed. However, radical and destructive surgery (hemipelvectomy) in one case (Case 8) might have been avoided with earlier preoperative HBO. Ray amputation of the third toe was the only debridement necessary in the patient who received eight preoperative HBO treatments (Case 4).

Drainage in all five instances of osteomyelitis (Cases 2, 3, 7, 9, 19) was slowed to a stop, but severe residual pain in one patient led to an above-the-knee amputation (Case 9). Patients with acutely exposed bone wounds were grouped with those who had soft tissue healing defects. Eleven of these patients were markedly improved, and two failed to benefit significantly from HBO.

Among the successes were two patients with amputation stump skin grafts (Cases 10, 12), one of whom had diabetes mellitus. The two patients with perirectal disease (Cases 16, 18) both benefited. In one with hidradenitis suppurativa, multiple sinus tracts were healed with a series of dives following surgical unroofing of the tracts. The patient who had a perirectal fistula whose condition was intractable even with a colostomy, developed good granulations. Three patients, each with exposed open fractures of the left lower leg and foot, developed good

Results of Hyperbaric Oxygen Therapy

Case	Age	Sex	Diagnosis	No. of Dives	Length	Depth*	Duration of Series	Results
1	65	F	CO coma.	1	2½ hr	33 ft	1 day	Continued coma. Pulmonary infiltrate. Treatment failure.
2	45	M	Osteomyelitis of right tibia.	45	90 min	45 ft	63 days	Asymptomatic after two weeks of treatment.
3	50	M	Infected iliac bone graft to mandible.	45	90 min	45 ft	79 days	Continued drainage with titanium basket in place. Basket removed.
			Persistent osteomyelitis.	30	90 min	45 ft	43 days	50% decrease in drainage, nonunion of fracture.
			Repeat mandibular bone graft.	12	90 min	45 ft	14 days	Drainage ceased, jaw stable.
4	52	M	Gas gangrene. Crush injury of left foot.	5	90 min	66 ft	3 days	Dramatic initial improvement, then slower but continued healing.
			Residual necrosis left foot.	6	90 min	45 ft	8 days	Amputation of left third toe only.
5	13	M	Crush injury of right leg.	1†	76 min	66 ft	1 day	Grand mal seizure, dive stopped. Some decreased toxicity. Leg amputated. Treatment failure.
6	34	F	CO intoxication. Carboxy-hemoglobin value of 31%.	1	23 min	66 ft	1 day	Cleared mentation.
7	26	M	Osteomyelitis of jaws due to multiple facial fractures.	20 33	90 min 90 min	45 ft 45 ft	28 days 100 days‡	Healing with increased stability.
8	22	M	Gas gangrene after traumatic amputation of right leg. Right hemipelvectomy.	7	90 min	66 ft	3 days	Lived. Had trunkal involvement.
9	51	M	Osteomyelitis right tibia, ant. compartment necrosis after vascular reconstruction.	59	90 min	45 ft	6 mos	Nearly complete healing, but AK amputation done for pain. Treatment failure.
10	19	M	Split thickness skin graft to left below knee amputation stump.	10	90 min	45 ft	12 days	Complete healing.
11	19	M	Stasis ulcer left ankle, hemoglobin SC disease.	10	90 min	45 ft	15 days	Healthy granulations but only 50% split thickness skin graft take. Treatment failure.
12	50	M	Ulcerated skin graft to below knee amputation right leg. Diabetes mellitus.	10	90 min	45 ft	14 days	Healthy granulations, 100% take of repeat skin graft.
13	28	M	Chronic intractable aphthous stomatitis.	16	90 min	45 ft	22 days	Nearly complete healing of ulcer.
14	19	F	Ischemic traumatic flap, laceration right lower leg.	17	60 min	60 ft	7 days	Distal third of flap sloughed, granulated, and skin grafted. Treatment failure.
15	31	M	Chronic staph infection of unstable left knee scar.	30	90 min	45 ft	2 mos	Half of area healed after treatment. Remaining half healed spontaneously.
16	40	M	Perianal hidradenitis suppurativa.	23	90 min	45 ft	2 mos	Progressive epithelialization of marsupialized sinus tracts.
17	24	M	Mult. open comminuted fractures left foot, necrotic skin and fat.	20	90 min	45 ft	2 mos	Healed with ankylosis but satisfactory ambulation.
18	57	M	Perirectal fistula unhealed with colostomy.	15	90 min	45 ft	19 days	Good granulations.
19	34	M	Osteomyelitis left tibia, nonunion bone graft, open wound.	18	90 min	45 ft	26 days	Open wound healed, decreased mobility of fracture site and bone graft.
20	41	F	Necrobiosis lipoidica diabetorum, left and right malleoli.	20	90 min	45 ft	26 days	Decreased drainage, healing.
21	19	M	Open left tibial fracture.	15	90 min	45 ft	21 days	Increased granulations, decreased mobility at fracture site.
22	41	F	Exposed left navicular and cuneiform bones.	15	90 min	45 ft	19 days	Increased vascularity of bone, viability of wound margins. Had dorsalis pedis arterialized flap.

* 33 ft = 1 atmosphere.

† 40 min O₂ prebreathing at surface.

‡ Equipment out of order for three months, prolonging duration to seven months.

granulations and the fracture sites were stabilized (Cases 17, 21, 22).

A patient with chronic intractable aphthous stomatitis healed in spite of his treatment series being cut short by a viral illness (Case 13).

A patient with necrobiosis lipoidica diabetorum had reduction of drainage and drying of ulcerated areas about both ankles (Case 20).

A patient with an unstable scar under the kneecap (Case 15) had a biopsy to rule out Marjolin's malignant ulcer. After 15 hyperbaric oxygen treatments, half the area healed. The remainder healed spontaneously.

Healing was incomplete in three other patients. One patient with a crush injury of the right leg had a seizure during the only dive attempted; toxicity was decreased, but amputation still was necessary (Case 5). Another patient had sickle cell trait and thalassemia (Hb SC disease) and insisted on continued smoking, so skin graft take for an ankle ulcer was poor (Case 11). A final patient with an enormous distally-based, traumatic flap wound of the lower leg may have been helped by HBO (Case 14). The middle third of the dusky flap over the midanterior shin may have been saved and tissue necrosis of the upper, distal third of the flap may have been lessened. However, subsequent debridement of the eschar, spontaneous granulation, and skin grafting were needed to heal the injury. It may be that gas gangrene was averted in this devascularized flap.

Discussion

Tissue partial pressures of oxygen vary with the distance from the capillaries, pO_2 and O_2 content in the capillaries, oxygen demand, and rate of blood flow. When tissue is hypoxic, pO_2 values are depressed (less than

4 mmHg). With hyperbaric oxygen administration, partial pressures of oxygen are restored to normal (5-60 mmHg). Concentric cylinders of pO_2 isobars can be imagined around each capillary. These are actually cone shaped because of the fall in pO_2 values along the length of the capillary. These isobar cylinders probably shrink in hypoxia, so that at a given distance from the capillary the pO_2 values are less than normal. It is as if the capillaries have been moved farther apart, leaving an hypoxic void between the outermost cylinder of pO_2 isobars. In fact, the capillaries actually may be farther apart anatomically in poorly healing wounds. In effect, hyperbaric oxygen swells these cylinders, causing them to overlap and restore normal partial pressures of oxygen to intervening tissues. Fibroblasts, struggling for survival in hypoxic tissues, are stimulated by the higher oxygen levels to resume their synthetic function.²

Summary

Twenty-two patients exemplify the applications and limitations of medical HBO therapy. In this series, 18 patients clearly benefited from the treatments and four did not.

References

1. *Compression Chamber Operations*. DAF HQ USAF, Washington DC AF pamphlet 161-27. 1976.
2. Finck PA: Exposure to carbon monoxide: review of the literature and 567 autopsies. *Military Medicine* 1966; **131**:1513-39.
3. Davis JC, Hunt TK (editors): *Hyperbaric Oxygen Therapy*, Undersea Medical Society, Inc., Bethesda, MD 1977.
4. Kaye D: Effect of hyperbaric oxygen on Clostridia in vitro and in vivo. *Proc Soc Exp Biol Med* 1967; **124**:360-6.
5. Unnik AJ Van: Inhibition of toxin production in Clostridium perfringens in vitro by hyperbaric oxygen. *Antonie Leeuwenhoek* 1965; **31**:181-86. ☆☆☆



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This picture of a Braille Chinese medical text, taken by George Morrice, M.D., of Newark, received an "Outstanding Entry" in this year's Journal Photographic contest. The picture was taken with a Nikon FE camera using a Nikkor 85 mm lens, and Ektachrome 400 film.

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Karl S. Messerly
United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, Connecticut 06830
Telephone: 203/661-9702

Regional

The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

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Letters ...to the editor

REFLECTIONS

To the Editor:

I enjoyed your article in the last State Journal entitled "Reflections in a Diamond Year." Every physician should be interested in the history of their own organization.

Also, I was glad to see "An historical footnote" regarding the Ohio Academy of Medical History.

I for one am happy to see someone speak up for the value of history.

/s/A. CLAIR SIDDALL, M.D.
Oberlin, Ohio

REMINDER

To the Editor:

I have just finished reading the July issue of the *Ohio State Medical Journal* and I think it is the best one I have ever seen. I was particularly interested in the way that the actions of the House of the resolutions was presented. It was concise and to the point and a good reminder of what we did last May.

Sincerely,
/s/RICHARD L. FULTON, M.D.
Columbus, Ohio

MISCELLANEA

To The Editor:

I have to compliment you on the quality of appearance and included material of the *Journal*. Allow me to suggest a "change for the better": I noticed that lately you have a column entitled MISCELLANIA (sic), as in page 466 of the August issue. This Latinogenous word is spelled in all dictionaries, and in the *JAMA*, as "miscellanea." Please check again your sources. Excuse a pathologist for being so particular; I swear I did not use my microscope to detect this little pathologic aberration!

/s/CONSTANTINE H. MAKRIS, M.D.
Athens, Ohio

Editor's Note:

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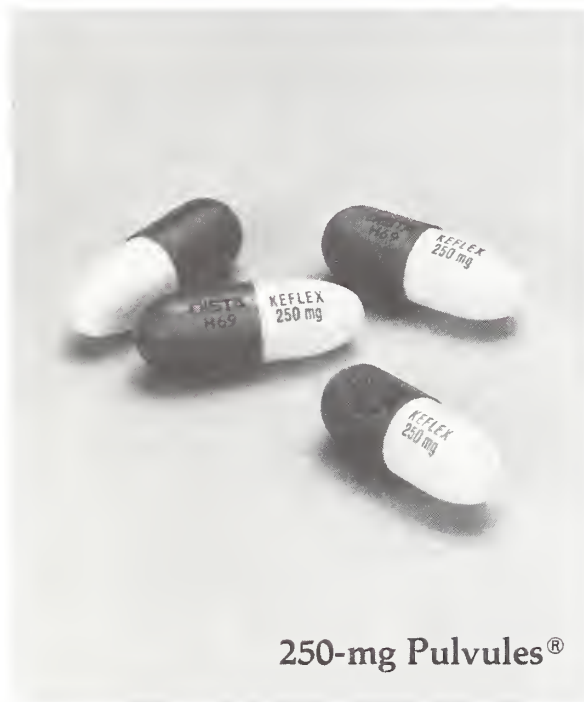
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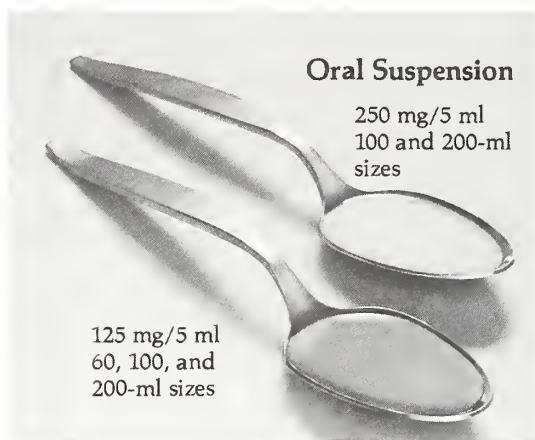
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CHARLES ADAMS, M.D., will serve as Vermilion's first member of the Erie County Health Board.

CARLOS B. ALVAREZ, M.D., Circleville, was elected president of the medical staff of Berger Hospital. Dr. Alvarez has been practicing in Circleville since 1960.

CARL F. ASSEFF, M.D., Euclid, was selected for participation in the 1981 class of Leadership Cleveland, a program of the Greater Cleveland Growth Association. Dr. Asseff is chief of staff at St. Vincent Charity Hospital.

ROBERT BLONDIS, M.D., Cleveland, received the Edward F. Meyers Outstanding Trustee Award from the Greater Cleveland Hospital Association. Dr. Blondis is chief of staff of Suburban Community Hospital.

The Wooster Kiwanis Club paid special tribute to **EVERETT BURGESS, M.D.**, and **ROBERT ANDERSON, M.D.**, for their lifelong contributions to the community.

FRANK A. CEBUL, M.D., Wooster, was reelected to the board of trustees of the American Cancer Society, Ohio Division, Inc. Dr. Cebul is a surgeon, a Diplomate of the American Board of Surgery, and has served the Wooster Community Hospital and Wooster Clinic since 1953.

RALPH COLLA, M.D., Canfield, was named a diplomate of the American Board of Obstetrics and Gynecology. Dr. Colla is on the staff of St. Elizabeth Hospital Medical Center.

JOHN CONDON, M.D., Columbus, was named chairman of the department of medicine of Riverside Hospital. **JAMES BOWERS, M.D.**, Columbus, was named president-elect, and **HOWARD LOWERY, M.D.**, Columbus, president of the medical staff.

EDWARD DROHAN, M.D., Cincinnati, was named emergency medical advisor for the Union Township Life Squad. Dr. Drohan practices internal medicine in West Chester and is active in various medical societies.

THOMAS FRYE, M.D., Columbus, was elected to radiological fellowship in the American Academy of Pediatrics. Dr. Frye is clinical professor of radiology and pediatrics at Ohio State University, and chief of the department of radiology at Children's Hospital.

JOSEPH E. GHORY, M.D., Cincinnati, was elected secretary and a member of the executive board of the Asthma Care Association of America, an international organization that sponsors clinical research, educational programs, and treatment centers with a special concern for asthmatic children.

Dr. Ghory practices pediatric allergy, and is president of the Ohio Society of Allergy and Immunology.

SHAWKI HABIB, M.D., Boardman, was named a Fellow of the American College of Cardiology. Dr. Habib is a cardiologist on the staff of St. Elizabeth Hospital Medical Center.



W.J. (Jack) Lewis, M.D. AMA-ERF's new secretary-treasurer.



Richard L. Meiling, M.D., improving Ohio health care.

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Colleagues (continued)

ROBERT S. KUNKEL, M.D., Cleveland, was elected president of the American Association for the Study of Headache.

W.J. (JACK) LEWIS, M.D., Dayton, was elected secretary-treasurer of the "AMA-ERF" at its annual meeting in Chicago. Dr. Lewis also is a member of the AMA Board of Trustees.

RICHARD L. MEILING, M.D., Columbus, received an honorary fellowship at the annual meeting of the American College of Hospital Administrators in Montreal. Dr. Meiling received the honor for his outstanding contributions to improved health care for all Ohioans as well as for persons from every state in the union.

C. DENNIS MILLER, M.D., is the new chief pathologist at Marion General Hospital and director of the department of pathology and laboratory services.

W.H. ROBERTS, M.D., Findlay, was recognized as the longest term employee at Blanchard Valley Hospital. Dr. Roberts has served the hospital for 27 years.

BROOKS H. SITTERLEY, M.D., Marion, was elected president of the Central Ohio Radiologic Society. **EDWIN G. DAVY, M.D.**, Marion, was elected chairman of the board of directors for Region III of Peer Review Organization, Inc. Drs. Sitterley and Davy are radiologists at Marion General Hospital.

JOHN M. TEW, JR., M.D., Cincinnati, conducted a clinical neurosurgery seminar and tour of the People's Republic of China at the request of the Professional Seminar Consultants. The tour included neurosurgeons and neuroradiologists who spent three weeks lecturing and making rounds with their Chinese colleagues in Manila, Peking, Pictaiho, Shanghai, Canton, and Hong Kong.

RICHARD WATTS, M.D., Lakewood, cardiologist at Fairview General Hospital, is the 1980 recipient of the Development for Progress Award. The award was bestowed upon him by the hospital's board of trustees and its development advisory council. Dr. Watts started the coronary care unit at Fairview in October 1964, one of the first 25 in the United States. Dr. Watts also is credited with taking an active role in the creation of WESHARE in 1977, an emergency program known as coronary paramedics.

JOSEPH P. WHITLATCH, M.D., Columbus, chief of staff of St. Anthony Hospital, was the recipient of the Sister Mary Ferdinand Award for outstanding service to the hospital.

JULIUS WOLKIN, M.D., Cleveland, was named neurosurgeon of the year by the Ohio State Neurosurgical Society. Dr. Wolkin has been on the medical staff of Mt. Sinai Hospital since 1947.

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STATE

STATE ISSUE 2 TO INCREASE PHYSICIANS' TAXES

The Ohio Public Interest Campaign (OPIC) tax initiative has been formally certified for the November 4th General Election ballot by the Secretary of State as **State Issue 2**. At least 170,601 valid signatures were needed to place the issue on the ballot, and 217,833 valid signatures were turned in. The certification followed the Franklin County Court of Common Pleas' rejection of a suit filed by the Ohio Manufacturers' Association to have the issue ruled off the ballot as a violation of the constitutional prohibition against the use of the initiative for tax classification.

State Issue 2 is designed to shift more of Ohio's tax burden to corporations (including physician corporations). Business and industry tax abatements would be eliminated and taxes on tangible personal property, such as tools, machines, and medical equipment, would be increased. Furthermore, households earning more than \$30,000 annually would have their taxes increased on a graduated scale. Under the proposal, homeowners, renters, and family farmers with incomes of less than \$30,000 would qualify for a tax credit if they paid more than 2.5 percent of their income in property taxes.

The Ohio Public Interest Campaign tax levy is Ohio's response to California's Proposition 13. Despite a sluggish start, the Campaign's current supporters include the AFL-CIO, the UAW, the Senior Citizens, the Ohio Council of Churches, the Black Political Assembly, and the Ohio Farmer's Union. OPIC is hoping to raise \$500,000 to \$750,000 to finance their issue campaign. The group refers to itself as a "grassroots organization" and has gained publicity by criticizing their opponents, the Ohioans for Fair Taxation Committee, for spending \$2 million in an effort to defeat the issue. The Ohioans for Fair Taxation include the Ohio Council of Retail Merchants, Ohio Bell, the Ohio Banking Association, the Ohio League of Savings and Loans, the Ohio Electric Utilities Institute, the Ohio Petroleum Council, the Ohio Contractors Association, the Ohio Society of Certified Public Accounts, and the Ohio Truckers' Association.

Disillusionment with President Carter's performance in the White House has weakened the participation of the labor vote in the November 4th general election. This apathy, if widespread, could mean a devastating lack of support for President Carter on election day. By involving

members in a close-to-home economic campaign, such as State Issue 2, organized labor leaders are optimistic they will increase the number of their labor union members going to the polls in November.

Recent estimates by the Ohio Department of Taxation state that, should State Issue 2 pass, the combined state and local tax increases would be \$1,037,000,000 — all but a \$150 million increase in personal income taxes would come from business through higher taxes on business income, increased property taxes, and repealed sales tax exemptions. State Issue 2 demands close scrutiny by all voters prior to the November 4th election.

OSMA's JAIL PROJECT RECEIVING NATIONAL ACCLAIM

In May, 1978, the OSMA Committee on Prisons and Jails recommended, and the Council of the Association approved, OSMA participation in the AMA Program for the Accreditation of Medical Care and Health Services in Jails.

The OSMA's program, one of only 24 nationwide, has been recognized as one of the nation's most successful. The Health Care Systems in fourteen Ohio jails have been accredited to date, more than double the number accredited by any other state. Nationally, approximately 60 jails have been accredited.

Working with minimum standards of health care developed by physicians, correctional officers, sheriffs, and ex-offenders, the OSMA has been providing technical assistance to correctional officials and jail physicians to upgrade existing health care services. A formal on-site survey is conducted by OSMA staff and a physician from the OSMA Prison and Jails Committee to ascertain that the recommended changes have been instituted.

Through the efforts of the OSMA working with the responsible jail physicians, sheriffs, correctional and medical personnel, the AMA recently accredited three Ohio facilities: the Lorain County Correctional Institute (William A. Sigalove, M.D.), the Cincinnati Community Correctional Institute (William R. Kelly, M.D.), and the Defiance County Jail (Ben Lenhart, M.D.). A special thanks goes out to Doctors Stacey H. Besst, John F. Test and V. L. Cotterman who assisted with the on-site accreditation surveys.

The OSMA Jail Health Program has been extended for a third year and will be soliciting additional facilities in the next few months.

LAME DUCK SESSION ALMOST CERTAIN

With the leadership in both Houses of Congress indicating that they see no way for the Congress to finish its necessary work by the October 4 election break, it appears that the strangest of all political animals will be viewed this fall — the lame duck. The majority leadership in both Houses have scheduled November 12 as the return date. In the **Congressional Record**, Senate Majority Leader Byrd listed 21 measures, not including the fiscal year 1981 appropriations (13), that must be concluded before adjournment. Also, the House must still pass a reconciliation bill, and the 2nd Concurrent Budget Resolution for FY1981 must be passed. Health professions education was the only health matter on the list.

MENTAL HEALTH SYSTEMS (S 1177)

On August 22 the House passed by a vote of 277-15, S 1177, an Act to revise and improve the federal programs of assistance for the provision of mental health services. The Senate passed its version of the bill on July 24.

The House version of the bill would extend the existing Community Mental Health Centers Act for one year through fiscal year 1981. The bill's substantive provisions would then take effect in 1982 with authorizations of \$152 million for FY1982, \$177.5 million for FY1983 and \$200 million for FY1984. The unifying concept of the bill is to give individual states a greater say in the provision of mental health services.

Significant provisions of the House version of S 1177 would: target mental health funds for "priority population" groups and the chronically mentally ill; require, beginning in FY1982, that a grant application for preparation or operation of a CMHC, or for "priority populations" must receive the approval of state mental health authority before the HHS Secretary could approve it; require, beginning in FY1984, that a grant application for nonrevenue-producing activity must receive the approval of the state mental health authority to be funded; and authorize the HHS Secretary to make grants to assist ambulatory health care centers to participate in the provision of mental health services to patients.

The House version also contains a provision for bonus pay for Public Health Service physicians. The President vetoed such raises earlier this Congress but the Congress has granted substantial raises to military and VA physicians over Presidential vetoes.

The Senate version of the bill is very similar. Originally, the Senate bill contained a federally mandated "bill of rights" and advocacy system to enforce those rights. That provision was deleted on the Senate floor (see **LR**, August 1, 1980). The Senate version does require states to develop

advocacy programs as a condition of receiving federal funding under the bill.

TOO MANY MDs?

The finishing touches on the long-awaited report on health manpower needs were being made at the same time the House was acting on the bill authorizing aid for medical education. The verdict in both cases was that we are headed into a physician surplus.

The report by the Graduate Medical Education National Advisory Committee (GMENAC) comes after three years of study and is designed to be the major federal policy statement on the medical manpower outlook. Surpluses were forecast down the line, including nonphysician providers.

The House was slated to approve a medical manpower bill sharply phasing back capitation aid for medical schools on grounds sufficient physicians are being turned out. The report by the House Commerce Committee argues that federal assistance must be reduced because the supply and demand situation for physicians in balance now with future prospects of a physician overabundance unless the government puts on the brakes.

The most immediate impact will be on the nation's medical schools, which are facing a period of hunkering down after many years of expansion.

The report estimates there will be a surplus of 60,000 physicians within 10 years and 130,000 by the year 2000. Most specialties will be oversupplied, including family medicine. The largest surpluses were seen in surgery, obstetrics, radiology, and general internal medicine. Shortages were forecast for psychiatry, emergency medicine, anesthesiology, and a few more. Other specialties were estimated to be in balance, including dermatology and otolaryngology.

The report is expected to take a strong stand against any further expansion of the numbers of nurse practitioners, physicians' assistants and other nonphysician providers, contending that this would aggravate the physician surplus problem. At the same time, GMENAC recommends higher pay and broader responsibilities for these groups.

A series of preliminary recommendations was drafted to reduce sharply the numbers of alien and U. S. citizen graduates of foreign medical schools.

One of the most important proposals was for a 10 percent reduction in admissions to medical schools between 1981 and 1984. Even a complete halt in the training of some specialties would not suffice to prevent a surplus within 10 years, the report said.

The looming surplus was not seen as solving what GMENAC considers the number one manpower problem — the maldistribution of physicians by specialty and by location. Many recommendations were made in this area, including continuation of the National Health Services Corps and higher reimbursement levels for physicians in shortage areas.

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, **The Journal**, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of **The Journal**. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of **The Journal** for additional listings.)



PATHOLOGIST: With forensic pathology subspecialty available September 1980. Has passed specialty board examination in anatomic and clinical pathology; eligible in forensic pathology in spring 1981. Interested in institutional or governmental practice and full or part-time academic appointment. Would like suburban metropolitan or metropolitan community of 50,000-1 million people. Contact Box P-59 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: In July 1980 will be available for practice and eligible for specialty board exam. Seeking solo or small group practice in community that is rural with metropolitan ties, suburban metropolitan or metropolitan with population of 15,000-100,000. Contact Box P-60 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: With cardiology subspecialty. Diplomate of the Board of Internal Medicine; in July 1980 will be eligible in cardiology and available. Full-time academic appointment desired in suburban metropolitan or metropolitan community of 50,000 or more people. Contact Box P-61 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: Trained in invasive and non-invasive cardiology. Diplomate of the Board of Internal Medicine; available July 1980 and eligible in cardiology June 1981. Desires solo or group practice in community of 30,000-100,000 people, rural with metropolitan ties, suburban metropolitan or metropolitan. Contact Box P-65 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

OBSTETRICIAN/GYNECOLOGIST: Available July 1980. Eligible for specialty board examination June 1980. Interested in solo or small group practice in a community that is rural with metropolitan ties, suburban metropolitan, or metropolitan with a population of 50,000 to 500,000. Prefers areas 1, 2 or 5. Contact Box P-56 c/o Ohio State Medical Journal.

SURGEON: General. Eligible for specialty board examination and available for practice in July 1980. Interested in solo practice with part-time academic appointment or in full-time academic appointment. Desires suburban metropolitan or metropolitan community with population of 50,000 to 1 million. Contact Box P-62 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

SURGEON: With plastic surgery subspecialty. Interested in solo or small group practice with full-time or part-time academic appointment. Prefers community no larger than 500,000 people. Diplomate of American Board of Surgery; eligible in plastic surgery and available for practice in July 1980. Contact Box P-63 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

PEDIATRICIAN: Eligible for specialty board exam in 1981. Prefers group practice in area 2, 3 or 5 in community of 15,000-1 million people that is rural with metropolitan ties, suburban metropolitan or metropolitan. In July 1981 will be available for practice. Contact Box P-64 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

SURGEON: Cardiovascular thoracic with general and transplantation surgery secondary specialty. Available July 1980. Desires suburban metropolitan or metropolitan community of 50,000 or more people. Interested in solo, small group or institutional practice and/or academic appointment. Has passed specialty board examination in general surgery; eligible in cardio-thoracic July 1980. Contact Box P-50 c/o Ohio State Medical Journal

UROLOGIST: Available July 1980. Interested in solo or group practice anywhere in Ohio. Eligible for specialty board examination May 1980. Contact Box P-53 c/o Ohio State Medical Journal.

FAMILY PRACTITIONER: Desires small group practice in community of 15,000 to 50,000 that is rural with metropolitan ties or suburban metropolitan. Prefers areas 3 and 5. Will be board eligible and available in July 1981. Contact Box P-72 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: Available for practice July 1981 and board eligible in September 1981. Would like solo or group practice in rural community with metropolitan ties or suburban metropolitan area of 15,000-500,000 people. Contact Box P-71 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

GENERAL SURGEON/GENERAL PRACTITIONER: Prefers community that is rural with metropolitan ties or suburban metropolitan with population of 50,000-500,000 in area 3 or 5. Eligible for specialty board examination in internal medicine in 1976; will be eligible in general surgery June 1980. Available for practice July 1980. Contact Box P-66 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: Available December 1979. Interested in solo or small group practice in community that is rural with metropolitan ties or suburban metropolitan with population of 15,000 to 500,000 anywhere in Ohio but area 4. Eligible for specialty board December 1979. Contact Box P-51 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1980. Eligible for specialty board examination June 1980. Desires community of 100,000 or more people that is suburban metropolitan or metropolitan. Interested in group practice, part-time academic appointment with part-time practice, or institutional practice. Contact Box P-45 c/o Ohio State Medical Journal.

^{*must*} ~~should~~ What you know about the Ohio Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- A pharmacist who receives a prescription for a brand-name dangerous drug may dispense any generically equivalent drug of the brand-name dangerous drug prescribed if the drug to be dispensed has a lower, regular, and customarily retail price than the brand-name dangerous drug prescribed and if the practitioner has not written in his own handwriting "Dispense As Written" or "D.A.W." on the prescription, or when an oral prescription is given, has not expressly indicated that the prescription is to be dispensed as communicated.
- No physician, dentist, veterinarian, or person licensed to prescribe any drug shall be liable for civil damages or in any criminal prosecution arising from the incorrect substitution by a pharmacist of another drug for the prescribed brand-name drug.
- The failure of a physician, dentist, veterinarian, or other person licensed to prescribe a drug to write "Dispense As Written" or "D.A.W." on the prescription shall not constitute evidence of the prescriber's negligence unless the

prescriber had reasonable cause to believe that the health condition of the patient for whom the drug was intended warranted the prescription of a specific brand-name drug and no other. No licensed prescriber shall be liable for civil damages or in any criminal prosecution arising from the interchange of a generically equivalent drug for a prescribed brand-name dangerous drug by a pharmacist, unless the prescribed brand-name dangerous drug would have reasonably caused the same loss, damage, injury, or death.

Rx

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Karen S. Edwards

"Agent Orange" effects studied

The Veterans Administration (VA) is using an outside group of 15 physicians and scientists to advise them on the effects of herbicide spraying in Vietnam and the current and future health of veterans who served there between 1962 and 1971.

The VA has also developed a Chloracne Task Force to help educate VA physicians on an accurate diagnosis of the skin condition attributed to exposure to dioxin, the trace contaminant in Agent Orange, the herbicide that was in use in Vietnam during the time of U.S. involvement there.

Just in time for the football season . . .

A new Division of Sports Medicine has been established at the Ohio State University to provide more extensive education in the health and medical care of athletes.

Robert Murphy, M.D., associate professor of preventive medicine, has been appointed head of the division, which is also one of the first of its kind in the country.

Following an interdisciplinary approach, the division will work with physicians and medical students in general medicine, physical medicine, emergency medicine, family practice, and orthopedic surgery to provide comprehensive education, research and patient care experiences. Continuing education for interested

practicing physicians and health education for the community will also be provided.

The division will be part of the Department of Preventive Medicine, which is chaired by Martin Keller, M.D.

"This program will allow greater coordination of the sports medicine teaching of medical students and residents in various fields," said Keller. "Sports medicine requires the attention of preventive and clinical medicine, as well as the basic sciences that contribute to our understanding of the health effects of physical activity and athletic performance. This is important for the health of the entire community."



Up in smoke

The medical, legal, and economic significance of smoking as it relates to the occupational setting was one of the topics covered by a recent statewide conference on "Smoking and the Workplace."

The conference, sponsored by the Ohio Department of Health and other agencies, including the Ohio State Medical Association, was targeted to large state industries, whose occupational pollutants — when combined with cigarette smoke — offer the greatest hazards to employees.

As Loren L. Hatch, D.O., of the National Institute on Occupational Safety and Health pointed out, unknown reactions may occur from the more than 2,000 compounds in cigarette smoke plus new chemical substances which are continually introduced into the workplace.

A second part of the program dealt with suggestions and resources for developing employee programs and incentives to reduce smoking in occupational settings.

Meetings

"EKG Interpretation and Arrhythmia Management," October 31-November 1, Carrousel Inn, Cincinnati, Ohio. Credit: 13 hours, Category I; fee: \$245. Contact: International Medical Education Corp., 64 Inverness Drive East, Englewood, Colorado 80112.

"First International Congress of Private and Independent Doctors," January 12-17, Sydney Hilton, Sydney, Australia. The purpose of this Congress is to bring together doctors from all over the world who are interested in preserving the tradition and rights of private medical practice. Contact: Jon Powis, Fox Public Relations, 5th floor Sentry House, 61 Lavender Street, Milsons Point NSW 2061, Australia.

"Ultrasound at Vail — Second Annual Seminar," March 21-28, The Lodge at Vail, Vail, Colorado. Speakers include Drs. John Hobbins, Peter Cooperberg, Michael Johnson, E.A. Lyons, Terry Silver. Contact: Ultrasound at Vail, P.O. Box 6093, Cherry Creek Station, Denver, Colorado 80206.

Ohio physician simplifies oxygen measuring

A new oxygen electrode, designed to quickly and accurately measure oxygen levels in living tissue, has been designed by William Whalen, M.D., of Bainbridge, Ohio.

The new electrode can be inserted into the skin through a hair-like hypodermic needle, only an inch in length, and provide immediate information about oxygen levels during open-heart surgery, for example, where an adequate supply of

oxygen must be kept in the patient's blood.

Other possible applications include measuring the oxygenation of the blood of newborn infants and monitoring infants to predict and prevent possible sudden infant death.

The device is made to be used with another piece of equipment which provides a digital read-out. An optional printing recording system to provide permanent records of results is also being tested.

CPR requirement revised

The Joint Commission on Accreditation of Hospital's (JCAH's) Board of Commissioners voted to revise a previous requirement mandating cardiopulmonary resuscitation (CPR) training for all members of the hospital medical staff.

The revised JCAH requirement now specifies: "Staff members should be encouraged to participate in pertinent self-assessment programs and in basic cardiopulmonary resuscitation training." This requirement becomes effective immediately.

Because of concerns expressed by practicing physicians, JCAH's

Standards and Survey Procedures (SSP) Committee reviewed JCAH's previous CPR requirement for physicians and recommended this change to JCAH's Board.

Joint Commission standards still specify that members of nursing staffs document participation at least annually in CPR training. However, the method and extent of training is left to the discretion of each facility. The CPR training requirement for nursing staffs may be fulfilled through certification or other evidence of practical training or competence in CPR skills.

Salt wash

The Food and Drug Administration has approved a salt tablet kit for disinfecting soft contact lenses.

The new kits are designed to avoid the potential health problems associated with the earlier salt tablets. The size of the tablets are smaller, 135 milligrams compared to the 250 milligram tablets previously available. Also, the plastic mixing bottle is only large enough for one day's supply of solution, and is marked to indicate how much distilled water should be

added to get the proper strength solution.

FDA Commissioner Jere Goyan explained, "The smaller tablets and bottle will permit the user to mix only enough solution for one day's use. With no leftover solution, the chances for bacterial contamination are reduced. Also, the marked bottle will help lens wearers avoid the problems of improperly diluted solutions, which can damage the soft lenses and irritate the eyes."

MISCELLANEA

"Advice for the Patient" is a lay-language volume of drug use information, designed as a reference book for patients in hospitals, medical offices, and pharmacies. The book is 320 pages and contains over 400 drug monographs. Orders or inquiries should be addressed to USPC-Drug Information Division, 12601 Twinbrook Parkway, Rockville, Md. 20852.

A new AMA booklet, "The American Health Care System: Issues and Facts," synthesizes information on costs, the public's attitude toward medical care, national health insurance, and the composition and growth of the physician labor force. Data and statistics on the characteristics of the U.S. population, morbidity and mortality, the health care system, national expenditures and financing, and physician manpower are also included. Accompanying the 56-page booklet is a *Fact Sheet on Physicians*, covering topics from fees to licensure. Copies are available from AMA Order Dept., OP-088, P.O. Box 821, Monroe, Wis. 53566. Cost is \$3 each for 1-10 copies; \$2.50 each for 11-49; and \$1.75 each for 50 or more. Orders should be prepaid.

Current exposure to sodium and potassium is discussed in a new AMA book, *Sodium and Potassium in Foods and Drugs*. Among the subjects discussed are the technology of sodium in fermented and processed foods and the sodium content in prescription and over-the-counter drugs. The book is intended as a reference for physicians, dietitians, health professionals, and students, as well as for use in patient education programs. The AMA has testified to regulatory agencies that "some technological uses of sodium-containing substances might have to be modified or abandoned," and has suggested improved food labeling for consumers who want to reduce sodium intake beyond avoidance of table salt. Cost of the book is \$5. Write AMA Order Dept., OP-80, P.O. Box 821, Monroe, Wis. 53566.



COST EFFECTIVENESS

Psychiatry in the 1980s: a cost-effective medical specialty

By Richard Dorsey, M.D. and Manuel
Gordillo, M.D.

Historically, the cost effectiveness of psychiatry has been viewed with some skepticism by laymen and other physicians, resulting in significant financial constraints in the private sector. Psychiatric diagnosis often has been seen as imprecise, and treatment as ineffective, causing some estrangement between psychiatrists and other physicians.

Changes in Psychiatry

Standardized diagnostic criteria, supplemented by evolving use of laboratory testing, have produced substantial improvements in diagnostic reliability and prognostic accuracy. Our ability to match patients to the appropriate treatment has improved markedly, and psychopharmacological treatment of many mental illnesses is approaching the results reached for diabetes, hypertension, and arteriosclerosis.

Psychiatry units have proliferated in general hospitals, with an increasing trend toward general medical treatment of mentally ill patients. Simultaneously, the state hospital system has made a major effort to discharge patients and return them to the community, resulting in a net shift of hospital and outpatient care from the public to the private sector.

Finally, psychiatrists as a group have increasingly reaffirmed their primary role as physicians, using the facilities, tools, and concepts common to other medical specialties. The "remedicalization" of psychiatry has already led to much closer working relationships between psychiatrists and other physicians, a trend likely to accelerate in the next few years.

Effectiveness of Psychiatric Treatment

Pharmacotherapy: The same standard applies to psychotropic medications as to all other drugs released for marketing in the United States. Effectiveness must be proven by "substantial evidence," defined as two or more well-controlled studies from

which experts can reasonably conclude that a drug works. Like the cardiac glycosides, insulin, antirheumatics, and antihypertensive drugs (and unlike antibiotics), most psychiatric medications control diseases, but do not cure them. Thus, much of psychopharmacology is concerned with obtaining and maintaining remissions, or retarding the natural course of an illness.

Electroconvulsive therapy: Numerous studies, including a small number using sham ECT as a control, have clearly demonstrated the effectiveness of this modality in severe depressive disorders. With properly selected patients, optimal pharmacotherapy approaches optimal ECT in effectiveness, but ECT still works for a few drug-resistant patients, and for patients who cannot tolerate the adverse effects of antidepressant medications.

Psychotherapy: Numerous controlled studies have shown that short-term, reality-oriented psychotherapy produces better results than no treatment in neuroses and psychosomatic disorders. A few studies have shown direct symptomatic reduction, while the majority have demonstrated better life adjustment with consequent reduction in stress and stress-related symptoms.

The effectiveness of long-term psychotherapy has been difficult to demonstrate, partly for methodological reasons. However, for carefully selected patients, positive results have been demonstrated with regard to reduced utilization of other medical services by patients undergoing long-term psychotherapy.

Interactions: A number of excellent studies have shown that pharmacotherapy and psychotherapy can produce additive benefits. In depression (the best-studied disorder), pharmacotherapy tends to produce an antidepressant effect, while psychotherapy does better with social and interpersonal adjustment. In the treatment of schizophrenia,

antipsychotic medications are generally indispensable, with psychotherapy alone being ineffective for all but a small subgroup. However, psychotherapy plus pharmacotherapy produces better results, particularly with regard to medication compliance and social functioning, than does medication by itself. Finally, in the treatment of psychosomatic disorders (eg, peptic ulcer disease, ulcerative colitis, asthma), psychotherapy plus appropriate medical management can result in substantially greater improvement than medical treatment alone.

Cost Effectiveness of Psychiatry

The National Institute of Mental Health estimated the economic cost of mental illness in the United States as \$31 billion in 1975. Of this, \$14 billion was accounted for by the direct cost of the treatment system, with indirect costs (lost productivity, chiefly through disability and death) accounting for \$17 billion. Alcohol abuse, which some authorities consider the nation's leading public health problem cost an additional \$43 billion.

Unlike most other medical specialties, psychiatry and psychopharmacology have very low capital and technology costs. Many mentally ill patients, particularly those with associated physical or psychosomatic disorders, can be treated appropriately in a medical setting, if nurses and other personnel receive adequate training. Even where standard psychiatric units are required, as in the treatment of involuntarily hospitalized patients, the equipment costs are far lower than for other specialized units.

Nor do the laboratory costs associated with psychiatry approach those of most other medical specialties. To some extent, this may be regrettable, since better laboratory tests would probably improve our diagnostic accuracy and therapeutic results. However, many of the medical tests now done, particularly on

psychosomatic patients, have a relatively low yield and thus high cost in relation to benefit.

Cost Effectiveness

Pharmacotherapy: In psychiatry, as in the rest of medicine, drug therapy is generally the most cost-effective treatment modality. The cost of medication itself usually is negligible in the context of hospital care and modest in comparison with physician time on an outpatient basis. The decline in the state hospital population following the introduction of chlorpromazine, the reduction in prolonged hospitalization and morbidity with the antidepressant drugs and lithium, and the reduction in anxiety-related somatic symptoms with the benzodiazepines have all produced societal paybacks many times in excess of the costs of these medications.

Psychotherapy: Twelve of thirteen well-designed studies have shown reduction in medical care utilization among patients receiving some form of psychotherapy. A West German study found an 85% reduction in average hospital days per year for the five-year period following mental health treatment, primarily with psychotherapy. A study by Kaiser-Permanente found reductions of 62% in outpatient medical visits and 68% in hospital days by the fifth year after psychotherapy with 21% and 52% reductions, respectively, at the end of the first year. Blue Cross of Western Pennsylvania found medical-surgical expenditure reduction of 57% when the period of approximately two years after psychotherapy was compared with a similar period before, and estimated that the savings from reduced medical-surgical care were 133% of the cost of the psychiatric treatment provided. In most instances, brief psychotherapy was the treatment used, though for a small number of patients longer-term therapy was given.

"The National Institute of Mental Health estimated the economic cost of mental illness in the United States as \$31 billion in 1975."

Conclusions

As other physicians are gaining renewed interest in the psychosocial aspects of medicine, psychiatrists are making new discoveries in the biology of mental illnesses, and conducting much more rigorous research in the field of psychotherapy. A renewed medical orientation promises to make psychiatry one of the most cost-effective specialties in the coming decade.

Richard Dorsey, M.D., is a member of the Ohio Psychiatric Association and practices psychiatry in Cincinnati, Ohio. Manuel Gordillo, M.D., past president of the OPA, practices psychiatry in Lakewood, Ohio.

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HOLY CONGRESS!

(Is there nothing sacred?)

Editor's Note: Once in a while, out of the ocean of news releases, magazines, and just plain junk that crosses an editor's desk, a real beauty floats to the top. Such was the case with the following article. The trouble is, we don't know where it came from, we don't know who sent it and we

don't know who wrote it. But it's great, we thought our readers would enjoy it, so we're printing it. We hope that one of our readers will be able to tell us who wrote it so we can give proper recognition to its author.

I have been asked to make a brief report on P.L. 93-649A, the National Church Planning Law, known popularly as the Heaven-Can-Wait Act. The extent of the problem I will be discussing was pointed out recently in a special task force study titled "The Utilization of Church Facilities in America."

This document depicted shocking conditions of low occupancy, duplication and limited utilization (particularly during weekdays), all of which proved we are one of the most over-pewed nations in the world. Few people realize that the average occupancy level is 42 percent and that rarely do the churches use their capacity except on Easter, Rosh Hashanah and Christmas. Many churches conduct only one service and rarely more than two. Facilities remain idle for six days out of each week, with a few minor exceptions of the sewing guild, choir practice, bingo and rummage sales. The study noted several examples of churches being located within a few blocks of other churches, and in some cities, two or more churches have \$50,000 pipe organs playing the same music. This was a setting that required drastic action, and the Congress responded to the need with the passage of the National Church Planning Law.

The cornerstone of P.L. 93-649A has been the formation of Church Systems Agencies, whose function it is to correct the duplication of religious facilities and at the same time to assure access, acceptability, availability, comprehensiveness, cost containment and quality sermons to the American church-going public.

The authors of the bill had some

difficulty in arriving at how to design the governing bodies of the CSAs. It was clear the existing crisis was due to the lack of planning by church authorities, therefore, a broader citizen involvement was required. The final resolution was to mandate a governing body of consumers and providers with a majority being consumers. Providers were defined as clergy, deacons, ushers, choir members, trustees and anyone associated with church affairs and members of their families. It was argued that this meant that consumers would be composed almost entirely of nonchurch-goers, agnostics and atheists; but it was apparent to all that the church establishment was responsible for the mess, and, therefore, they badly needed the grassroots wisdom of the consumer.

The act included certain guidelines for use by the CSAs in carrying out their role, and despite the fact that they were meant only as suggestions, most CSAs have adopted them as mandates for their planning. Two of the key guidelines are:

An Occupancy Level of 75 Percent:

It has been clearly established by academicians, well-versed in the study of church administration, that the well-managed church can operate at an 84.5 percent occupancy level, and, therefore, it is not unreasonable to expect a 75 percent level for those churches which have less efficient management. Churches with less than 65 percent occupancy should be closed, enabling the other churches to increase their occupancy levels.

A Minimum of 300 Funerals Per Year:

With an appropriate service area, each church should be able to provide a variety of funeral services at the rate of 300 per year. Services should be held on non-Sabbath days to increase utilization of the facilities; and if Sunday burials must be scheduled, they should be conducted in churches of Seventh-Day Adventists. In those areas of younger populations, the CSAs should make an appropriate age-ratio adjustment allowing for a reduction of this rate.

Congress likewise was aware of the potential benefits of shared services, as a way to reduce capital expenditures for new construction, reduced use of supplies and increased utilization of church personnel. CSAs have urged churches to form group purchasing consortia to save on the price of wine, candles, collection baskets, etc. There was an attempt to develop a standardized National Bible and Hymnal as an obvious cost containment device, but no one was willing to serve on the committee assigned to this task, so it was not included in the final regs.

All in all, the National Church Planning Act has become another landmark achievement for Congress. It has been demonstrated that millions of dollars of needless capital costs can be saved by the CSAs. The over-pewed scandal has been defined, and already remarkable progress has been achieved. As one looks back, it is surprising that we didn't think of this approach sooner. The President, we understand, is planning to apply the same concept to schools, post offices, railroads, and fast-food outlets.

God help them all!!

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Meeting the press

By Karen S. Edwards

Editor's Note: If Mary McGarey's face looks familiar to you, it's probably because you've seen her at one of the OSMA, AMA or specialty conventions you've attended . . . or perhaps at the hospital you staff . . . or maybe in your own office.

Ms. McGarey has been reporting medical news for the Columbus Dispatch for 36 years, a job that has placed her at all of the scenes mentioned above at one time or another.

Here, she draws on her own experience with physicians and her own position in the media to look at physician image . . . its past, its present, and its future.

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

The Ohio State Medical Journal: You have been a medical reporter for some time, and are familiar with the kind of public image that physicians have had in the past. But what can you tell us about the physician's image today?

Mary McGarey: I don't like the word image. Image implies an imitation. In fact, I've even looked it up in the dictionary, and it means a "projection of something that is not necessarily true." The word bothers me from that standpoint. I do think that physicians project an image of sincerity and concern through their patients, and if doctors would worry less about their "public image" as such, and concern themselves with communicating with their patients on a personal basis, then I think this image of the physician as a sincere and concerned person would come through much more quickly.

Journal: Do you feel that the physician is not spending much time, or enough time, with his or her patients?

McGarey: I think that doctors are like everyone else — you just can't lump them together with such a broad statement. Some of them do spend enough time, some of them don't.

Journal: How do you think the public views the physician's role, then? Is it generally positive?

“. . . if doctors would worry less about their 'public image' . . . and concern themselves with communicating with their patients on a personal basis, then I think this image of the physician as a sincere and concerned person would come through much more quickly.”

McGarey: Yes, I think so. I think overall it certainly is. However, there has been a great deal of thought, in recent years, that the physician is a \$100,000-a-year man, who drives a Cadillac, and takes three vacations a year. I don't think that newspapers have contributed to this image as much as other media — but I think it is *now* an image — and I think doctors, themselves, have contributed to it somewhat.

Journal: Do you think the public feels physicians are overpaid?

McGarey: I don't think they feel they're overpaid. I think they feel physicians are preoccupied with the material side of professional success. However, I don't think this shakes the public's confidence in their doctors. It bothers them, but I think they see it as a problem brought on by mounting health care costs and the demise of the system. They feel health care will soon get to the point where they can't pay for it anymore.

McGarey: Here again, there are physicians and there are physicians. It's hard to say. I think people expect to be a little more removed from the specialist because they see him in a different, more transitory situation, unless there is something of a chronic problem. Certainly one of the criticisms of the profession, however, is with surgeons, for example, who won't take the time to explain to the patient what they're going to do and why they're going to do it — and see to it that the patient understands.

Journal: Then you don't feel that there has been any significant change in the way the public views physicians, with the possible exception of the specialists?

McGarey: I don't think there has been much of a change. Of course, people have become so much more knowledgeable about medicine, and I think they're inclined to expect more answers from their doctors because

seminar. Do you think that more physicians should take courses in media training?

McGarey: I think that communication is a basic part of the physician's function, and is becoming even more so in the new era of preventive medicine, which they themselves are sponsoring. A bigger part of their role now is in the area of education — keeping people well.

Journal: So you do see health education as a growing role for physicians?

McGarey: Oh yes, definitely.

Journal: Do you think your own contact with physicians has improved as a result of this new role?

McGarey: Yes, my own contact with physicians has improved immeasurably. I think they are becoming more accustomed to the media and the need for information.

"I think they should teach a little more about communication in medical schools. Sometimes, if a doctor is not explaining things to a patient or a patient's family, it's because of an inability on his part to convey the information . . ."

Journal: This image, then, has been brought on by *recent* developments in health care. What can you tell us about physician image in the past, under the more traditional forms of practice? Has the public's view of the physician changed a great deal?

McGarey: I don't think the one-on-one patient relationship with doctors has changed a whole lot. I think where people get "hung up" is in the hospital where they have to deal with specialists and tests and a lot of frightening things they don't understand.

Journal: So the "image" begins to shake a bit under these circumstances?

McGarey: Yes. I think that's where the impersonality begins.

Journal: Do specialists have a worse image than the family or general practitioner?

they're coming from a little better background of information themselves.

Journal: Then do you think that the physician now has to assume the role of patient educator, as well as his/her more traditional role as healer?

McGarey: I was just thinking about that this morning. I think they should teach a little more about communication in medical schools. Sometimes, if a doctor is not explaining things to a patient or a patient's family, it's because of an inability on his part to convey the information in terms that the patient or the family will understand. The more knowledgeable a physician is, the more apt he is to complicate matters with complex terminology.

Journal: The AMA has recently introduced a media training seminar for physicians. In fact, at the last annual meeting of the OSMA House of Delegates, the OSMA Department of Communications sponsored such a

When I first started covering medicine, it was not at all unusual to encounter a physician in Columbus who would refuse to talk to the press. It was a long time before any of them would allow us to use their name in connection with a story on a certain procedure being done. I think both of those have changed now. I can still remember, though, a physician here in Columbus who had had a bad experience with a reporter in Canada shortly after he left medical school. Based on that experience, he refused to talk to any reporters the whole time he was here.

I never insist on using a doctor's name in a story, although I think it's only fair for a man who does something newsworthy to get credit for it. Sometimes, I feel that the physicians feel that way too, but they are held back by the profession's ethics, and by censure from their own colleagues.

Journal: Do you think that will change?

McGarey: I hope so. It certainly needs to change. I think the profession needs to identify and recognize their outstanding people. It would upgrade the entire profession.

Journal: What is your opinion of organized medicine, as represented by the OSMA and the AMA?

McGarey: Better. I've always had a good relationship with the OSMA. So many of its members are really my friends. But looking at the AMA and getting back to that word "image," the AMA's image has improved considerably. They've turned themselves around and now are leading the way in involving doctors in cost containment and cost awareness.

Another place where the AMA has taken leadership is in the area of government control. They saw that the only way they could have any effective input into what was happening in that area was to become a part of the negotiations, and they're doing that now.

Journal: How would you suggest that the medical profession change a negative public image, or improve what you see as a basically positive image?

McGarey: I think it would start with something as simple as scheduling appointments so that they could see patients in a reasonable amount of time after their arrival at the office. It's the "high and mighty" attitude that people resent — especially if it's a person as busy as a physician being kept waiting for two hours to see the doctor. That's just bad office management. Improving the profession's image could begin there and go on up to the hospital setting and the "God complex" that some physicians have there.

Journal: Do you think a physician changes when he goes into a hospital setting?

McGarey: No, I think that the doctor-patient relationship changes, however. The hospital is a cold, frightening place for most patients, and the doctor

in his white coat seems so unapproachable in this kind of setting.

Journal: Going back to *your* profession as a reporter and medical writer, how do you find your medical stories?

McGarey: I read a lot and I read a lot of medical publications. Often a story will come from a news release, or from something I hear about, and I wonder if the same thing is going on here in Columbus. Sometimes I hear from individual patients. Doctors are rarely the source for a news story, but that really doesn't bother me. In fact, I'd much rather hear about a new surgical technique or whatever from a grateful patient.

Journal: All right, let's say you learn about a new surgical technique that's being practiced elsewhere in the country. Where do you go from there in finding out what's being done locally. How do you gather facts and develop your sources?

McGarey: Well, usually a story about a specific type of surgery comes to me from the hospital's public relations department, after the surgery has been developed to a certain level of service. Actually, within my experience as a medical writer, this development of public relations departments in hospitals is fairly new, and can be a good thing or a bad thing, depending on the person involved. But you go to the people who are doing the work and talk to them, gather your facts, and decide how to best illustrate the article.

Journal: How do you develop your physician sources for the story? Do you get names from the public relations department?

McGarey: Sometimes. However, I prefer to talk to the doctor directly rather than through a public relations department, which must sometimes be done if you use the contacts they give you.

Journal: Do you have your own "network" of physicians whom you can contact as sources on various stories?



Columbus Dispatch medical reporter, Mary McGarey.

McGarey: I know a great many physicians, just from my own experiences in medical reporting, so I usually know where to start on a story. This "network" has just evolved with time. But my contacts are also a good way for me to check whether a technique or whatever is really new. The biggest pitfall in medical writing, however, is overstating — to raise false hopes. An experienced medical writer knows that. As a matter of fact, at several medical seminars I've attended, I've heard medical writers put the brakes on two or three medical researchers who have overstated their own case a bit. The writers have heard these "great reports" year after year and so many of them don't pan out. Of course, there's that standard joke: "I've saved so many mice. But how many people have you saved?"

Journal: How do you foresee physician image as shaping up in the future?

McGarey: It's oversimplification to say it like this, but I suppose the way they *want* it to shape up. I think physicians can still shape their own profession.

A-B-C . . .

How does **your** waiting room rate?

By Ann C. Calkins



"My 'A' office is a squarish room . . . the light is good . . . and new patients are made to feel at ease immediately."

Ann C. Calkins received her B.A. from Radcliffe College, and holds a graduate library science degree from CRWU. She resides in Cleveland Heights, Ohio.

Editor's Note: While the *Journal* rarely prints articles from consumers, we felt that this article raised some concerns which were worth presenting to our membership. The article does not, however, reflect official OSMA or *Journal* policy.

I think the medical care I get is terrific! No complaints. And my physicians, specialists though they may be, are as a rule almost as friendly and comfortable as the family physician who used to visit my bedside and give me a stick of Juicy Fruit gum when he had finished his treatment. But that space between the door from the medical building corridor and the door where I finally see the physician is another matter.

Perhaps I am moved to express my feelings because I have experienced recently what I regard as an "A" office and a "C" office. The contrast was so great that I began to wonder how much attention physicians give to waiting rooms. I don't mean the decor or the magazines, although they are factors in the total picture. Do you ever visualize yourself as the anxious patient walking in your door? Is the mood in your office going to calm him or irritate him and make him even more tense, more anxious?

Let me describe my "A" and "C" offices. Both are in big city medical complexes. (Perhaps the problem does not exist or is different in a small-town setting. Familiarity with the office does tend to smooth things over a bit, but with our system of specialists, we all see more new physicians, and I, at least, am affected by the outer office even when I have been there before.)

An "A" office

My "A" office is a squarish room with chairs and tables around the

"If I could achieve only one goal in the improvement of waiting rooms, it would be to eliminate those frosted sliding windows."

edges as well as grouped in the middle. The light is good — some sort of ceiling fluorescent — warm and pleasant even without windows. The chairs are nondescript but comfortable; the artwork is good; and there is general reading material and pamphlets relating to this physician's specialty. An innovation the last time I was there was a viewer for educational film strips. (What a lot of potential there is in that! I could envision strips on insurance, Medicare information, what to expect in a hospital visit, home patient care, etc.)

One corner of this room is cut off by a diagonal wall which is open above a counter level, to the room beyond where people are working — telephoning, making appointments, filing. Usually one receptionist is at the counter to greet the patient conversationally when he enters the office. I have been there many times, and I am greeted enthusiastically by name, and I observe new patients also are made to feel at ease immediately. Several physicians have offices inside, and each patient is called in by a cheerful, relaxed nurse who is able to ease tensions by her casual conversation.

¹In the corner of the waiting room is a table with hot water and instant coffee and tea. If you are one of those rare physicians who runs reasonably close to schedule, this would not be important; but in my "A" office, the physicians are often late, and that cup of coffee really helps. (It also makes me feel happier when the receptionist, instead of sounding defensive, commiserates when there are delays.) I might even suggest that the receptionist keep on hand a pad of writing paper to offer an irate or fidgety patient.

A "C" office

My "C" office is long and narrow, entered at one end. There is a toy corner at the far end for the young patients. In between is a corridor of chairs, lamps, and tables that I suppose the decorator thought were dark and restful. I find the deep blues and greens depressing and none of the lamps the right height to read by unless you lean in and hold the book right under the bulb. On one side wall is my least favorite of all physicians' office features — the frosted glass sliding door window. On it is taped a sign that says, "Please register. Knock and wait for receptionist."

On my first visit, I knocked and when the window slid back I was greeted by a bored young woman who was drinking *her* coffee (none for me) and talking to another young woman about a mutual friend. She stopped long enough to take my name and slid the window shut again. Eventually she opened the door, called my name, looked around blankly, clearly not remembering which patient went with the name, and escorted me silently into the physician's office.

At the end of my visit, I stood at her counter waiting to pay my bill and make another appointment. Her total boredom and lack of concern were not at all what I needed! The physician himself is kind, friendly, and full of humor, but he apparently has never thought to look for those qualities in his staff.

If I could achieve only one goal in the improvement of waiting rooms, it would be to eliminate those frosted sliding windows. I suppose the office staff considers them a great protection against the snooping public. Maybe

they were designed to protect the patient from noises of typewriters and telephone conversations, but I firmly believe they do more harm than good. Even clear glass would be better — it would not isolate the patient so completely from the environment he is about to enter. Many of my "B" offices have these windows, but if the staff is anywhere near approaching my ideal, they leave the window open 90% of the time.

A "B" office

One of my "B" offices used to have an incredibly imaginative playroom for children. It was a dentist's office and my children, because of the atmosphere and the physician who took the time to create it, have never had the fear of dentists' offices that many children have. I regret that as his office increased in size and efficiency it lost the playroom; but it does still have earphone stories and the best magazines. Lamentably, it also has a closed frosted glass window.

Doctor, I urge you to imagine you are a patient in your own waiting room. Even better, conspire with a friend who is observant and whose judgment you admire. Run a few test samples — try sitting in another waiting room and then return to your own. Who knows, "you may surprise yourself. And if it's not a pleasant surprise, you owe it to your patients to make some changes."

I don't know which of you I might have to visit next month or next year, but I'm sure that I'll be a better patient if I arrive at your office door having had a pleasant, relaxing experience in your waiting room.

BOOK SHELF

Improving Patient Medication Compliance. By Robert T. Weibert and Donald A. Dee, Medical Economics Books; \$9.50.

Authors Robert Weibert and Donald Dee believe that when it comes to medication, "involve the patient as a partner in therapy."

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The book is 180 pages, and is available for \$9.50 per copy (plus \$1.00 handling charge) from Medical Economics Books, Box 157, Florence, Ky. 41042.

Patient Records: A Guide for Your Practice. By the American Society of Internal Medicine, \$7.50.

This new "how-to" guide offers internists all the information needed to design an effective record-keeping system, including helpful tips on office work flow, filing systems, and computer use.

The book includes both problem-oriented and nonproblem-oriented medical record systems, as well as such medical record-related issues as confidentiality and patients' access to their records. Suggestions also are offered on how to choose the method of record keeping best suited to a particular practice.

While specifically addressing the needs of broad-based internists, the guide also is helpful to the subspecialty practices of internal medicine.

The book is available for \$7.50 per copy from the American Society of Internal Medicine, 2550 M St., N.W., Suite 620, Washington, D.C. 20037.

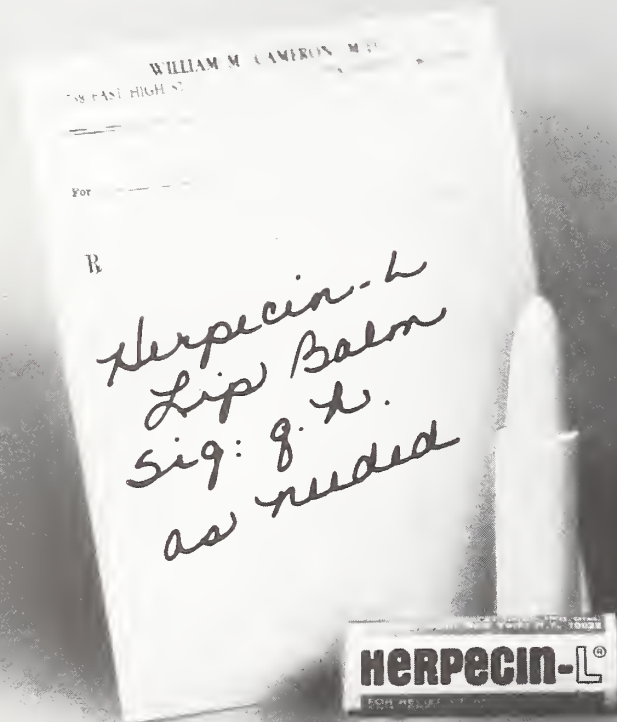
Your Skin and How to Live in It. By Jerome Z. Litt, M.D., Corinthian Press; \$4.95.

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(photography courtesy of T. William Evans, M.D.)

URGENCY OR EMERGENCY?

By Carol W. Mullinax

The difference between urgent and emergency care may seem to be a question of semantics, but Ohio health care consumers soon will be judging for themselves.

Several urgent care centers or free-standing emergency rooms have sprung up across the state in the last few years and several more are in the planning stages. These centers are designed to offer a type of health care which promises all the advantages of an emergency room — nonappointment, after-hours care — with none of the disadvantages — long waits and higher costs.

The majority of the several hundred urgent care centers presently operating in the United States are not affiliated with a hospital. These free-standing emergency rooms offer the community walk-in, outpatient health care on a 12- to 15-hour a day, seven days a week, 365 days a year basis. At any given time, a typical center is usually staffed by a physician, a registered nurse, a lab technician and a receptionist.

T. Williams Evans, D.D.S., M.D., spokesman for a group of developers who are building these centers around the state, says they are capable of "filling the void" which presently exists between the health care provided by a patient's family physician and the emergency room.

As president of Emergency Medical Associates, Inc., an organization which provides physicians for six hospital emergency rooms in central Ohio and Pittsburgh, Dr. Evans is well aware of the problems facing emergency rooms today.

He says most emergency rooms are "over-utilized" by noncritically ill patients who either don't have a family physician or who can't get in to see him or her in an emergency. Calling these noncritical trips to the emergency room time consuming and expensive, Dr. Evans says the urgent care center is the answer to the problem.

Dr. Evans and his colleagues are banking on the fact that the public will agree. The Urgent Medical Care

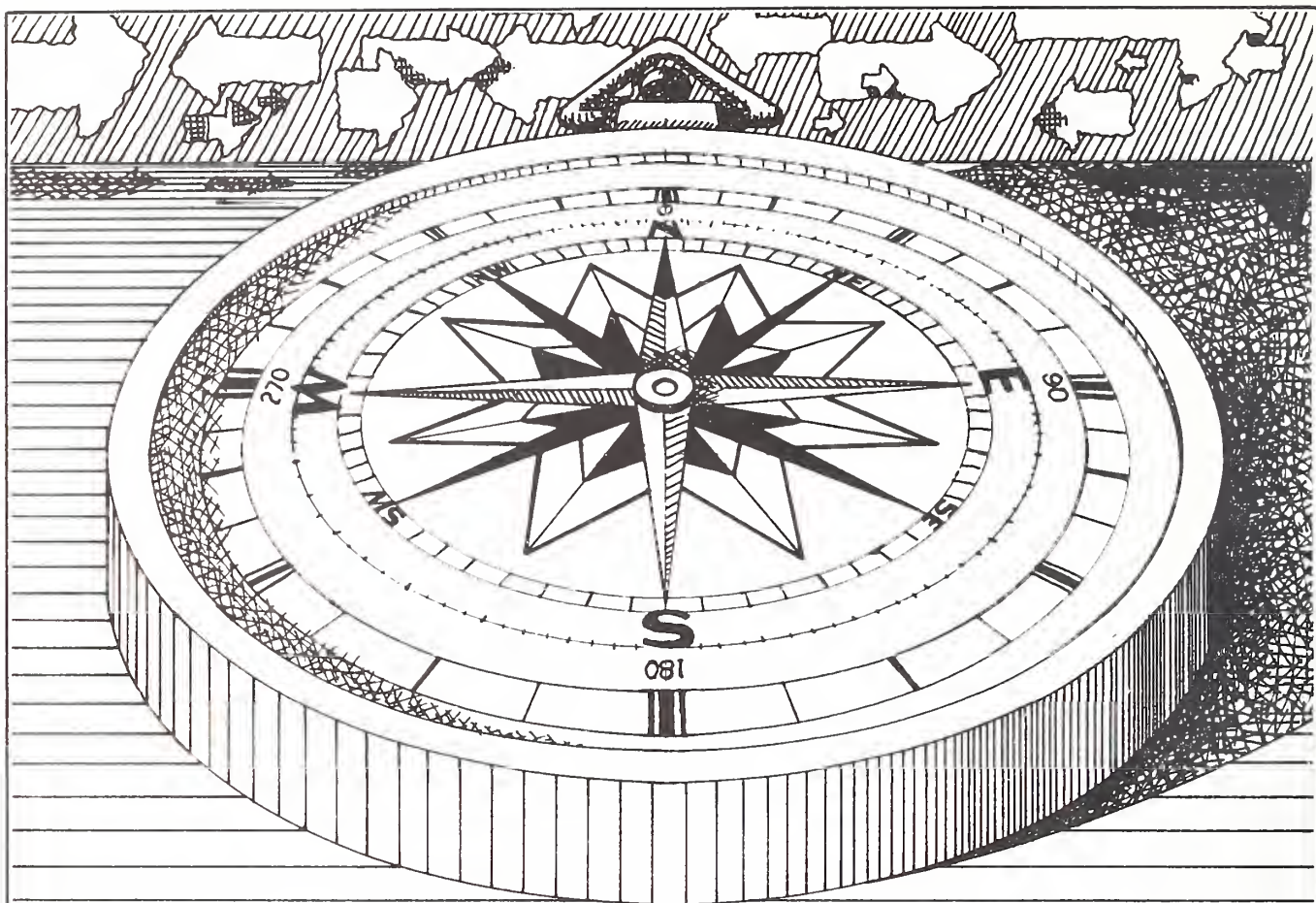
Center on Morse Road in Columbus which was recently built at a cost of \$400,000 is one of five such centers they have planned for the Columbus area. In addition, they are in the process of acquiring sites for centers in Cleveland, Cincinnati, Toledo, Akron, Dayton, Indianapolis and Pittsburgh.

And thus far it looks like money well spent. The Morse Road Center which opened in January of this year presently is seeing an estimated 45 to 50 patients a day and it is not the only center operating in the Columbus area.

Nearby there is the Karl Road Urgent Care Center which opened several months after the Morse Road Center and in Westerville, Grant Hospital operates the Grant-Otterbein Urgent Care Health Center — a hospital-affiliated, free-standing emergency center.

Dr. Evans says the centers are so popular because they are responding to a real need in the community. Their convenient operating hours and short waiting time are more suited to today's busy lifestyle. Patients can

Carol W. Mullinax is the Assistant Director of the OSMa Department of Communications, edits *Synergy*, and is a contributing editor of the *Ohio State Medical Journal*.



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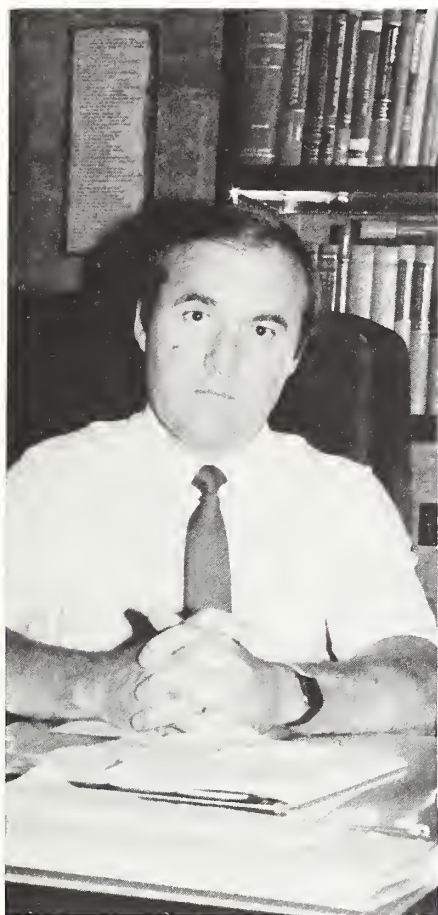
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T. William Evans, D.D.S., M.D.

walk in after work and see a physician in just a few minutes. The longest anyone has had to wait for treatment at the Morse Road facility is seven minutes. Dr. Evans says patients find this aspect of urgent care very appealing.

John Paul King, M.D., agrees. Dr. King is the medical director of the Kingscourt Clinic and Emergency Room, a free-standing emergency room located in Reynoldsburg. When the center opened in May of 1973 it was one of five or six free-standing

"We feel the critically ill patient should go to the emergency room . . . We are more interested in those patients who are going to . . . go to the emergency room and sit there three, four, or five hours before they are seen."

emergency rooms in the country. Dr. King says he opened the clinic because for years he had been the only physician in the area with evening hours and, as a result, was "seeing emergencies for all the other doctors for miles around anyway."

While patients are finding the hours convenient, some health care professionals are saying these urgent care centers may be one answer to another problem facing medicine — rising health care costs. As is expected, a trip to the center usually is less expensive than a trip to the emergency room. Dr. Evans says the average bill for a visit to his Morse Road Center is \$30 to \$40 less than a comparable trip to the emergency room.

One of the ways he cuts costs — but something which is not practiced by all free-standing emergency centers — is to require direct payment at the time of treatment from the patient. If the visit is covered by a third-party payer, the patient is reimbursed directly.

If patients find this monetary policy demanding, they don't seem to be complaining. But this makes sense considering the typical urgent care center patient. According to a Preliminary Survey of Free-Standing Emergency Centers released in

February 1979 by the Orkand Corporation, the majority of urgent care centers are located in suburban middle-class or upper-middle-class white communities.

And, Dr. Evans says, the typical urgent care patient is often unorthodox in another way. Marcus Welby notwithstanding, he says many of their patients don't have a family physician and don't really want one. They prefer to trade the traditional continuing care given by a family physician for the convenience of the centers.

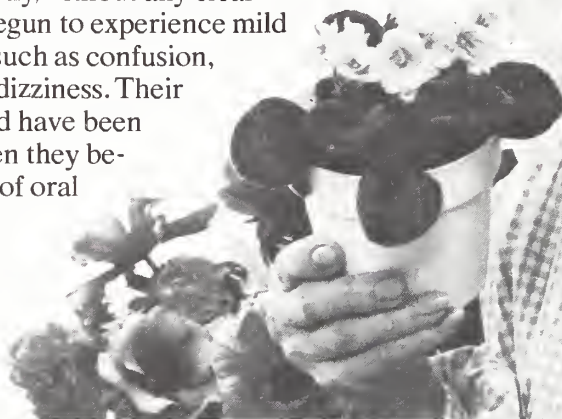
This has caused some people to charge that the free-standing emergency centers will woo patients away from the family practitioner with a resulting loss in quality of health care. They say these centers are capable of giving "episodic" or "casual" health care only and that the patient will be the one who suffers for it.

While admitting that there are some patients who consider the centers a replacement for their family doctor, Dr. Evans stresses that it is not a role the centers wish to play. He says "We don't particularly want to be their family physician," adding, "We under no circumstances want to compete with private practitioners."

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On the other side of the health care coin, the reaction of emergency room physicians seems to be mixed. Some of these physicians feel that the centers are responding to a real need in the community for convenient, no-wait health care. Pointing to the fact that only 15 to 20 percent of patients who visit the emergency room are admitted, they say these centers may be the answer for the other 80 to 85 percent.

But will these people know who they are? Some ER physicians charge that the urgent care centers are billing themselves as emergency rooms and patients may find it confusing. Families may show up with a critically ill patient who must be transported to a hospital for proper care or they may show up after hours and, in both instances, waste precious time in getting help for the patient.

Dr. Evans says all of his urgent care centers will be "equipped just like any emergency room" and can indeed treat the critically ill patient. But, he stresses, he does not see that as the role of the urgent care center. "We feel

the critically ill patient should go to the emergency room," adding, "We are more interested in those patients who are going to have to go to the hospital emergency room and sit there three, four or five hours before they are seen." At present, critically ill patients who are taken to his urgent care center are stabilized and transported to the hospitals.

Another controversy surrounding the free-standing emergency centers is the question of licensing or standardization of care. At present these centers are classified as physicians' offices and are exempt from Certificate of Need and from the jurisdiction of local Health Systems Agencies. Some physicians feel, however, that free-standing emergency rooms, like hospital emergency rooms, should have uniform criteria or comprehensive guidelines for equipment and operation. In several states local HSAs have made moves to have free-standing ERs placed under their jurisdiction. But so far these attempts have failed.

Recognizing the problems, two years ago the American College of Emergency Physicians created an ad hoc committee to study free-standing

emergency centers. According to the June 1979 issue of the Journal of the American College of Emergency Physicians: "The Committee's task has been to define the term 'free-standing emergency care center,' to prepare a recommendation for the ACEP Board of Directors on whether the College should support the concept of the centers and to recommend objectives and develop guidelines for the centers. To date, the committee had done all of the above, including recommending endorsement of these centers."

The staff person to the ACEP's ad hoc committee says the recommendations of the committee are "still under advisement." Stating that since urgent care center's impact on the entire health care system, including hospitals, must be considered, ACEP's Board of Trustees has referred the recommendations to their hospital committee for further study.

The proliferation of the free-standing emergency centers has raised and will continue to raise some interesting and important questions about the practice of medicine. Only time will tell what their role in the delivery of health care will be.

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OSMA Health Planning Consortia

By Rebecca J. Doll



Keeping a hand on the government's health care plans

Editor's Note:

In 1974, Congress enacted P.L. 93-641, the National Health Planning and Resources Development Act which created a health planning system composed of a network of local, state and national planning agencies.

In theory, health planning was to begin at the local level and work up to the national level. However, it became apparent shortly after the law's enactment that the federal government would make most of the decisions and reduce the local and state agencies to little more than advisory panels.

Last year, Congress adopted P.L. 96-79, the Health Planning and Resources Development Amendments of 1979, which extended the law for three years. Although there was some easing of federal control, the state agencies gained little and the local agencies even less. What little control the local agencies did have, soon

became concentrated in the hands of individuals who had little knowledge of the realities of providing care to people on a daily basis.

Recognition of this danger led OSMA to hire a full-time Director of Health Planning to assist physicians in working with the local planning agency.

What has since developed is a series of health planning consortia, comprised of county medical societies who have united to work with the local agencies in providing stronger physician input into health planning. Consortia now exist in the Health System Agency (HSA) areas around Cleveland, Marietta, Cincinnati and Toledo.

Although all of the consortia have had varying degrees of success, the Toledo consortium has made great strides in a relatively short period of time.

In this article, two Toledo physicians and OSMA's Director of Health Planning tell about their accomplishments and their plans for continued success.

Certificate of need.

Appropriateness review. Acute care planning. Bed reduction. These are but a few of the shiny, new terms with which physicians have had to become involved — terms which would eventually affect the very basics of health care delivery. Yet all were as alien to most physicians as medical terms are to plumbers.

The terms were contained in the 1974 National Health Planning and Resources Act which created a network of health planning agencies throughout the country. The purpose of the network was to assist communities in planning and allocating their health resources so as not to duplicate facilities and services, while at the same time, provide high quality, cost effective health care.

Suspicious of further government intervention into the practice of medicine, many physicians were reluctant to become involved with the HSAs. Those that did soon found that

Rebecca J. Doll is the Director of OSMA Department of Communications and is a contributing editor of the *Ohio State Medical Journal*.

there were very rigid rules and regulations which dictated how many "providers" could serve on HSA boards and committees. It soon became apparent that individuals with little or no health background began to determine the health needs of local communities.

Sensing a real danger, those physicians who were involved, sought help from their county medical societies and eventually, the OSMA. Such was the case with the county societies located in HSA District IV near Toledo.

"Our biggest problem," says Donnan B. Harding, Jr., who currently is the Toledo Academy of Medicine representative to the HSA was that we lacked the expertise and the people to deal with the HSA. Most of the things that confronted us were new — things we had never dealt with before. We had no past knowledge to draw from and it was a frightening situation to many physicians."

Growing concern about lack of physician input into HSAs and a cry for help from those who were involved, led to the OSMA's hiring, in 1978, of a full-time Director for Health Planning. His first task involved spending several months travelling around the state educating physicians

about the health planning process and why it was important that they become involved with their local HSA. This, says Dr. Harding, was very important because most physicians had no knowledge of how to work effectively within the structure nor the knowledge to interpret many of the regulations required by the federal government.

According to David W. Pennington, OSMA's Director of Health Planning, the next step was to get the presidents of each county medical society and the chiefs of staffs of each hospital within the HSA district together to map out strategies for working with the HSA.

"When we started talking to these people, they would say, 'but we already send a representative to each HSA board meeting,'" Pennington says. "But we tried to explain that the policy decisions which really affected the actual practice of medicine in the Toledo area were not being made at board meetings. They were being made during the task force and subcommittee meetings. Our goal then became one of getting physicians appointed to as many of them as possible."

John A. Devany, M.D., vice-president of the Health Planning Association in Toledo says that most

physicians are surprised to learn that the board and staff actually welcome more physician input.

"It's not really a question of them against us. It's a question of what's best for the community. The boards may have designated members, but all basically want to do a good job. They work under pressure from Washington and third-party payers to reduce costs by eliminating 'inefficient duplication of services' and at the same time are supposed to maintain or improve the quality of care. It's an impossible job for them without our input."

Dr. Harding agrees.

"The federal government sets up certain guidelines, but says that local people know what's best for local communities and charges the local HSA with carrying out the guidelines. But what really happens is that the federal government mandates certain things and if the locals don't go along with them, they lose their funding. This puts the local staff and board in a precarious situation when they know a specific mandate might not be in the best interest of their particular community. This then puts the staff into a position of doing number-based rather than people-based actions, because they have no knowledge of the workings of a hospital or what



"It's not really a question of them-against-us. It's a question of what's best for the community." — John Devany, M.D.

John A. Devany, M.D.

Donnan B. Harding, Jr., M.D. (left) discusses Toledo's successful health-planning consortium with David Pennington, OSMA Director for Health Planning.



goes into the actual care of a patient. That's where our knowledge and expertise as physicians are imperative."

Has the idea of a consortium been successful? Both Drs. Harding and Devany agree that it has.

"The real value of the consortium and OSMA's involvement in developing it is that we have learned how to approach the problem in a unified way," says Dr. Devany. "We've learned how to interpret the law and how to work with the boards and staff for the good of the community. I think we've gotten our money's worth from OSMA on this issue alone."

One specific example where OSMA was able to help was during the period when, according to the guidelines, Toledo was to have only four beds per thousand.

"We knew that was an unrealistic figure, but that's what the guidelines appeared to require," says Dr. Harding. "But further investigation of the law revealed that there were several exemptions that the community could invoke if it needed them. One of them, for example, stipulated that if a community has a certain percentage of the population over 65, it can increase its beds per thousand. We worked with the board and staff on this and after figuring out which exemptions we qualified for, we were able to raise the bed-per-

thousand ratio to 4.8. That may not sound like much but it is a significant increase and a much more realistic figure for our particular community. And we still were able to remain within the guidelines. The board was happy, the staff was happy, we were happy and the community was assured of high quality care. But had it not been for OSMA's input, specifically that of Mr. Pennington, we might never have gotten the exemptions."

Right now, the consortium is gearing up to deal with another one of those shiny new terms — appropriateness review.

According to the law, appropriateness review is defined as the degree to which a service meets the needs of a population served, in accord with criteria developed and published by HSAs and state agencies. The "appropriateness" of all existing institutional health services must be determined by next June.

If a particular service is found to be "inappropriate," third-party payers are not required to reimburse hospitals or physicians if that service is rendered.

"There is a real danger here," says Dr. Harding, "in that the hospitals will be forced to comply if the HSA deems the service inappropriate because they can't afford not to be reimbursed by the carriers. And in my mind, there is only one person who can decide what is appropriate medical care for

individual patients and that is the physician. If we don't become involved in this one, we're back to number-based rather than people-based planning, and the community is going to suffer for it."

Dr. Devany agrees. In a letter to the members of the Toledo Academy of Medicine he warned, "We must participate in this (appropriate review) on the local level, state level and national level. This is ten times greater a challenge to our practice than the malpractice crisis."

Although the current concerns now revolve around appropriateness review, both Dr. Devany and Dr. Harding stress that health planning is an ongoing process, not a temporary situation that exists this month on this particular issue.

"It takes a long time to develop a total picture of the whole issue and to develop our credibility among the various participants," Dr. Harding says. "The more involved we become and the longer we are involved, the better our credibility will be with the board, the staff and the community. They're already beginning to recognize that we as physicians are truly concerned about seeing to it that people in this community get the care they need."

November

1980 ANNUAL CANCER SYMPOSIUM "CANCER UPDATE": November 2; Fawcett Center For Tomorrow, 2400 Olentangy River Road, Columbus; sponsor: American Cancer Society; cosponsor: Ohio State University Comprehensive Cancer Center; 5.25 credit hours; fee: none; contact: Frances Helmick, R.N., American Cancer Society, Ohio Division, Inc., 1367 E. Sixth Street, Cleveland 44114, phone: 216/771-6700.

BIRTH, INTERACTION AND ATTACHMENT: November 9-12; Bond Court Hotel, Cleveland; sponsor: Rainbow Babies and Children's Hospital; cosponsor: Case Western Reserve Medical School; 18.5 credit hours; fee: \$150; contact: Marshall Klaus, Rainbow Babies and Children's Hospital, University Circle, Cleveland 44106, phone: 216/444-3752.

OF MEDICINE AND MUSIC/ UPDATE 1980: CARE OF THE POST MYOCARDIAL INFARCTION PATIENT: November 12; Amphitheater, Rainbow Babies and Children's Hospital, Cleveland; sponsor: Case Western Reserve University School of Medicine; 4 credit hours; fee: \$60, (dinner extra); contact: Ms. Amy, Office of Continuing Medical Education, CWRU School of Medicine, 2119 Abington Road, Cleveland, Ohio 44106, phone: 216/368-2408.

December

PERSPECTIVES IN OPHTHALMOLOGY: December 4-5; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$170, \$85 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

INFECTIONS IN OBSTETRICS AND GYNECOLOGY: December 10; Kent State University, Kent; sponsor: Aultman Hospital, Canton; 6 credit hours; fee: \$25, \$16 for residents; contact: Alvin Langer, M.D., 2600 Sixth St., S.W., Canton 44710, phone: 216/438-6214.

CONTINUING EDUCATION PROGRAMS

October

SYMPOSIUM SERIES 1980-1981: July 1980-May 1981; St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown; sponsor: St. Elizabeth Hospital; 48 credit hours; fee: \$20 per lecture; contact: Rashid A. Abdu, M.D., St. Elizabeth Hospital Medical Center, Youngstown 44501, phone: 216/746-7211.

CURRENT THERAPY XI: October 24-26; Shawnee State Park Lodge, Portsmouth; sponsor: Scioto County Medical Society; cosponsor: Ohio State Medical Association; 16 credit hours; fee: \$60 (meals and room extra); contact: Scioto County Medical Society, 1805 27th Street, Portsmouth 45662, phone: 614/354-5315.

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Health planning activities increase shown

Health planning activities by state medical associations have increased sharply since 1978, according to the 1980 AMA Federation Health Planning Survey. The questionnaire sought information on how the state societies implement health planning laws. Of the 35 respondents, nearly 30 have employed full-time health planning staff to aid physicians with state and regional issues. A majority of the societies reported having an impact on specific planning activities. Respondents also reported increased physician awareness and understanding of the health planning program and its process, accompanied by increased physician participation.

Obituaries

HARRY E. HARTMANN, M.D., Wellington; University of Hamburg, Hamburg, Germany, 1939; age 72; died August 15; member OSMa and AMA.

DAVID B. KING, M.D., Ocala, Florida; Indiana University School of Medicine, Indianapolis, 1928; age 76; died December 8; member OSMa and AMA.

GERALD KLEBANOFF, M.D., Boardman; Chicago Medical School, University of Health Sciences, Chicago, 1956; age 48; died July 11; member OSMa.

PAUL M. MOORE, M.D., Delray Beach, Florida; University of Michigan Medical School, Ann Arbor, 1922; age 81; died July 25, member OSMa and AMA.

MOSES PALEY, M.D., Cleveland; Case Western Reserve University School of Medicine, Cleveland, 1928; age 78; died July 18; member OSMa and AMA.

YAHYA RIDA, M.D., Elyria; Kasr-el-Aini Faculty Medicine, Cairo University, Cairo, Egypt, 1950; age 63; died August 18; member OSMa and AMA.

LUCIA C. TRANDAFIR, M.D., Cleveland; Friedrich Wilhelms University, College of Medicine Berlin, Prussia, Germany, 1943; age 66; died August 1; member OSMa and AMA.

FRANCIS WADSWORTH, M.D., Mansfield; Ohio State University, College of Medicine, 1933; age 71; died July 24; member OSMa and AMA.

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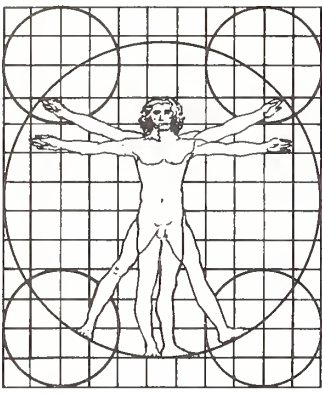
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CLINICAL & SCIENTIFIC

Influences on Graduate Medical Education: An Analysis of Historical and Contemporary Specialty Maldistribution

Stephen E. Peterson, Ph.D.
Alvin E. Rodin, M.D.

Factors in the development of graduate medical education (GME) are considered to determine reasons for the present imbalance in residency positions. Some contributing factors appear to be: an overall increase in the number of hospitals; development of specialization; use of residents to fulfill service needs; and reliance on foreign medical graduates to fill excess positions. Some barriers to correcting this imbalance include: hospitals' needs for service; changing needs for specialists due to fluctuations in utilization and delivery patterns; and lack of quantitative control mechanisms. It is concluded that institutional responsibility, as envisioned by the Liaison Committee on Graduate Medical Education (LCGME) in the proposed general requirements, will not create a better apportionment or "mix" of residency positions. Achievement of such would require a voluntary effort on the part of medical schools and hospitals.

IT HAS BECOME APPARENT that before long we will have an adequate supply of physicians, perhaps an oversupply, because of the addition of several new medical schools in the past decade, raising the current number to 122 in 1978,¹ and a significant increase in the number of students in classes of existing medical schools. Instead of an overall physician shortage, medical educators are focusing their attention carefully on specialty maldistribution which may pose a greater challenge in the 1980s than the overall physician manpower shortage of the 1960s and 1970s. The purpose of this article is to describe the origin and development of specialization, analyze historical and present influences and controls on specialization, discuss specialty maldistribution, and draw attention to crucial unanswered questions and issues which are likely to pose serious obstacles to the achievement of appropriate specialty distribution.

Development of Specialization

The origin of specialization can be traced to the internship, a period of hospital-based, supervised training, which began around 1865, as an avenue for entrance into the mainstream of private practice for a select few of the most promising medical graduates.² Increasingly viewed as a necessary period of practical experience for aspiring physicians, the internship soon became institutionalized as an essential component in physician training, supplementing didactic medical school curricula. Gradually, as almost all students took an internship, it came to be viewed as an essential period of generalist training, which could be supplemented with residency (specialist) training by the most favored or promising interns. With the elimination of proprietary medical schools, a reform hastened by the Flexner Report of 1909,³ the number of graduating medical students per year decreased, while the number of internship positions remained relatively constant. As with internship training, the number of residency training positions grew faster than the demand. As a result of the Hill-Burton Act of 1946, providing federal subsidy to build or remodel facilities, the number of hospitals in the United States increased significantly.⁴ Many hospitals developed new residency programs in order to utilize residents as a cost-effective source of physician manpower to meet rapidly expanding service needs. Thus, the imbalance was created between supply and demand for positions, although not as great today as in the past.

Recently, medical educators have focused on developing a coherent policy which will limit the number of foreign medical graduates (FMGs) entering residency programs in this country, yet provide quality GME programs for a limited number of physicians from developing countries. To date the report of the Coordinating Council on Medical Education (CCME), "Physician Manpower and Distribution: The Role of the Foreign Medical Graduate,"⁵ is the most deliberate attempt to develop such a

Dr. Peterson, Dayton, Head, Residency Education and Consultation Services, Wright State University.

Dr. Rodin, Dayton, Chairman and Professor, Department of Postgraduate Medicine and Continuing Education, Wright State University.

Submitted November 1, 1979.

policy. Relating to the excessive reliance on FMGs as a source of physician manpower, the following recommendations were made:

1. The US medical education system should provide a sufficient number of physicians to meet US health care needs.
2. Manpower shortage and geographic distribution problems should not be resolved by reliance on FMGs.
3. FMGs who seek opportunities for residency training in the United States should have professional competencies comparable to US graduates, adequate communication skills, and familiarity with US culture.

Until 1976 many of the surplus residency positions were filled by FMGs who were granted preferred immigration status by the Immigration and Nationality Act, which classified medicine as a manpower shortage occupation. Today, fewer FMGs, approximately 1,000 per year, are able to enter residency positions in the United States as a result of the Health Professions Educational Assistance Act (HPEA) of 1976, (Public Law 94-484) which restricted entry of FMGs.⁶

As alluded to previously, the initial development of residency programs was based upon not only the public's need for specialists, but also hospitals' needs for services, resulting in present specialty maldistribution. This imbalance is most evident in surgical specialties as a manpower surplus. As evidence of an oversupply in surgery, it is frequently pointed out that proportionally the United States has twice as many surgeons as England and Wales. It also has twice the surgery rate, 7,400 per 100,000 population for the United States, compared to 3,700 per 100,000 population for England and Wales.⁷ Because mortality and morbidity rates are equivalent for the two populations,⁸ it is difficult to explain such a high surgery rate in the United States, although cultural differences may be a contributing factor.

As evidence of the manpower shortage in primary care, public dissatisfaction with the availability of basic medical care and inappropriate overutilization of hospital emergency rooms usually are cited. Although there is a general lack of consensus on the magnitude of the primary care physician shortage, it is stated that good-quality primary care requires the services of 133 physicians per 100,000 population.⁹ If used as a "target" or ideal ratio, the primary care physician shortage for 1972 was estimated at 123,000 physicians.⁹ As a result of this manpower shortage in primary care specialties and surpluses in others, basic medical services have been scarce to some and unavailable to others. As highlighted in the Willard Commission Report of 1968,¹⁰ primary care physicians who provide basic medical care have four unique functions:

1. To serve as the first, readily available medical contacts for patients.
2. To act as medical care coordinators on behalf of patients, orchestrating the utilization of health care resources.
3. To integrate health care services, interpret services

to patients, explain the nature of illness, and discuss implications of treatments.

4. To function as patient advocates, assuring the provision of comprehensive and continuous care.

A scarcity of primary care physicians who would fulfill many of the foregoing functions has resulted in serious deficiencies in the provision of basic or personal medical care. Recognition of this unmet need by the general public has served as the impetus for numerous national reports. Most notable is the Millis Commission Report of 1972 in which the consequences of this deficiency are highlighted.

If the critically ill patient has a personal physician (primary care) the chances are good that his illness will be correctly diagnosed and he will reach the right hospital in time to benefit from the right physician. If he does not have a personal physician or cannot reach one promptly, he is almost forced to self-diagnosis. The chances that he will reach the right physician and the right hospital become substantially smaller. Thus we must recognize the insufficiency in the number of physicians.¹¹

Influences and Controls on Specialization

The problem of specialty maldistribution began with the sweeping reforms in medical education, made as a result of the Flexner Report of 1909.³ The major recommendation of Flexner, the need to transform medicine from an empirical to a scientific basis, has been accomplished in many respects, as a result of the development of specialization. Reaching an apex in the post-World War II era, specialization has, to a large extent, aided in developing medicine into the scientifically based discipline it is today. As a consequence, excessive emphasis has been placed on training in secondary and tertiary specialties, and insufficient emphasis on training in primary care specialties.

Recently, interest in health manpower on the part of the federal government has shifted to specialty maldistribution. Until 1976, the federal government was interested in increasing the overall supply of physicians, and through provision of federal dollars, assisted in the development of new medical schools and expansion of older existing schools. However, the HPEA Act of 1976 (Public Law 94-484) marked for the first time a shift in federal priorities away from attempting to correct the overall under-supply to specialty and geographic maldistribution.¹² As a condition to the provision of capitation support, calculated on a medical student per-capita basis, medical schools were required to have 35% of their residency positions in primary care specialties for 1977, 40% for 1979, and 50% in 1980. Perceived by many medical schools as an unnecessary federal intrusion into their internal affairs, some threatened to refuse capitation support, although few did. Meanwhile, medical schools, cognizant of the need for more primary care physicians, developed new residency programs and expanded existing ones.

The US Bureau of Health Manpower reports for 1977, 53% of all residency positions in the United States were in three primary care specialties, general internal

medicine, general pediatrics, and family medicine,¹³ already exceeding the goal established for 1980. However, in keeping with federal priorities for primary care, the National Institute of Medicine has recommended a substantial increase—to as much as 70%—in allocation of residency positions to primary care training programs.¹³

Although the problem of specialty maldistribution is generally acknowledged as valid, the task of determining appropriate allocation levels for residency positions is very difficult. The most definitive recommendations to date, by Morrow and Edwards in a 1976 article entitled "U.S. Health Manpower Policy—Will the Benefits Justify the Costs," are abstracted in the table.¹⁴ Morrow and Edwards have projected future growth in specialists-to-population ratios, assuming continuation of 1973-1974 first-year residency allocation levels.¹⁴ Congruent with public priorities

and the federal initiative, specialists-to-population ratios are likely to increase substantially for some specialties (71% for pediatrics, and 41% for internal medicine), but contrary to public priorities and the federal initiative, decrease in family medicine. For family medicine Morrow and Edwards¹⁴ recommended that the 1973 level, 942 first-year positions be increased substantially to approximately 4,000 first-year positions. This was supported by the Willard Committee and at its recent reunion in 1978 it recommended, as a national goal, that 25% of American medical school graduates enter family practice residency programs.¹⁵

Based upon the 16,134 first-year medical students in 1978,¹⁶ 4,033 family practice residency positions were needed to achieve the 25% allocation level. In 1978 there were approximately 2,200 first-year residency positions in

PROJECTED GROWTH IN SPECIALIST-TO-POPULATION* RATIOS
FOR 1973-74 RESIDENCY POSITION ALLOCATION LEVELS
AND RECOMMENDED ALLOCATION LEVELS†

Specialty	Continuation of 1973-74 Allocation Levels		Impact of Recommended Allocation Levels	
	No. of First Year Positions	Projected Growth (1990)	Recommended No. of First Year Positions	Projected Growth (1990)
Family/General Practice	942	none	4,000	23%
Internal Medicine	3,955	41%	3,700	39%
General Pediatrics	1,699	71%	1,300	51%
Dermatology‡	234	30%	200	20%
General Surgery§	1,074	3%	900	19%
Neurological Surgery	143	26%	100	8%
Orthopedic Surgery	591	33%	450	16%
Otolaryngology	266	22%	200	8%
Plastic Surgery	174	66%	125	38%
Thoracic Surgery	130	40%	100	27%
Urology	320	24%	300	23%
Obstetrics and Gynecology	1,003	20%	400	18%
Ophthalmology	495	21%	450	16%
Anesthesiology	747	35%	650	28%
Neurology	357	76%	300	63%
Psychiatry	1,472	31%	1,350	30%
Pathology¶	898	50%	600	27%
Physical Medicine and Rehabilitation	135	53%	125	53%
Radiology	1,076	47%	750	23%

* Death and retirement rate for active physicians assumed to be approximately 2% each year, for all except family/general practice, where 3.5% was assumed.

† Abstracted from the following with permission of authors: John H. Morrow and Arch B. Edwards, "U.S. Health Manpower Policy: Will the Benefits Justify Costs?" *Journal of Medical Education*, Vol. 51, Oct. 1976.

‡ Half of first-year dermatology and PM + R residents subtracted on the assumption that their first year of residency training was in internal medicine.

§ To estimate the number of first-year residents who will remain in general surgery, first-year residents in surgical subspecialties were subtracted from total first-year residents in general surgery.

|| Does not include child psychiatry.

¶ Does not include forensic pathology and neuropathology.

family practice—a difference of 1,833 positions.¹⁵ Conversely, to maintain 1973 specialists-to-population ratios, the allocation of first-year residency positions to some specialties, eg, plastic surgery, neurological surgery, and radiology, should have been reduced by 25% or more; others, eg, dermatology, general surgery, orthopedic surgery, otolaryngology, thoracic surgery, anesthesiology, and neurology, by 10% to 25%. It should be noted, however, that these recommended reductions and increases in allocation levels would not solve the maldistribution problem, as they would merely result in maintenance of 1973 specialists-to-population ratios, which are admittedly inappropriate to actual manpower needs.

Unanswered Questions

Determining the ideal mix of residency positions for the 23 specialties in which residency programs are approved by the LCGME¹⁷ is a difficult task. Initially, in order to compensate or correct for past imbalances, a greater number of positions should be allocated to the primary care specialties. When the appropriate mix of specialists is obtained, allocations should be reduced to maintenance levels. Conversely, a smaller number of positions should be allocated to residency programs in specialties which have manpower surpluses presently, and then increased to maintenance levels, if necessary. Employment of this approach would require more radical increases and decreases than those suggested by Morrow and Edwards.¹⁴ Also, because residency allocation levels should be made in light of consumer preferences and actual or perceived need, periodic adjustments will be necessary as utilization and delivery patterns fluctuate with a changing population. To this end the Graduate Medical Education National Advisory Committee (GMENAC) has been established by the Department of Health, Education, and Welfare (HEW), and given the charge of making public policy recommendations to the Secretary of HEW, which will result in a better match between specialty training and actual specialty needs. To date, although GMENAC has made no recommendations regarding the allocation of residency programs, it has released an interim report acknowledging the complexity of the graduate medical education system, and the multiple factors which influence physicians' specialty choices.¹⁸

Once initial and maintenance levels which will result in the ideal "mix" of first-year residency positions are determined, actual implementation and achievement is another hurdle. Hospitals traditionally heavily rely upon house staff to meet service needs, which may consume up to 50% of a resident's time, and they are likely to resist cutting back positions in manpower surplus specialties. Therefore, a mechanism will be needed to monitor and assure compliance with "target" levels. At present there is no such organization with control over that aspect of residency programs, including the LCGME. Decisions by the LCGME to grant accreditation to residency programs are based upon an assessment of quality rather than quantity. That is, accreditation decisions are not made

with consideration of national manpower needs. However, for individual programs, accreditation decisions are based upon the number of first-year positions allotted in comparison to available resources.

Unlike undergraduate medical education which is characterized by institutional responsibility, uniformity between schools, and external control of quality and quantity, graduate medical education is a loosely organized collection of autonomous programs operated by multiple disparate institutions. Presently, the LCGME is taking a step which could result in institutional responsibility for graduate medical education. In order to be accredited by the LCGME, all residency programs must meet two sets of requirements as set forth in the *Essentials of Accredited Residencies*,¹⁷ General (Part I) and Specific (Part II). In Part I the general requirements delineate the standards which must be met by all institutions and all programs, regardless of specialty. In Part II the special requirements delineate a separate set of standards, specific to each specialty. The LCGME currently is in the process of revising the general requirements. To date the proposed revision by the LCGME has been approved by the CCME, as required in the Council's bylaws. As a final stage in the approval process, each of the parent bodies comprising the CCME must ratify the proposed revision. With the exception of the AMA which has vetoed the proposed revision, all have approved it to date.

The impetus for the revision of the general requirements originated with the report of the Citizens Commission on Graduate Medical Education, entitled "The Graduate Education of Physicians."¹⁹ Regarding the need to improve specialty training, the Commission made the following recommendation:

We recommend that each teaching hospital organize its staff, through an educational council, a committee on graduate education, or some similar means, so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibilities of particular medical or surgical services or heads of services.¹⁹

As a result of this policy recommendation, the proposed revision of the general requirements stresses the importance of institutional responsibility for the educational validation of residency programs. Therefore, all institutions which sponsor residency programs will be expected to develop administrative systems which provide for: (1) allocation and management of resources; (2) selection of candidates; and (3) implementation of mechanisms which provide for the evaluation of specialty programs, instructors and residents. A policy statement promulgated by the CCME and approved by its sponsoring organizations in 1974, has been included in the proposed general requirements. In part, it addresses institutional responsibility for apportionment of positions between programs:

The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education;

(b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs.²⁰

The proposed general requirements will have the effect of removing some responsibility for decision making, eg, the apportionment of residency positions among different specialty programs, from the program to the hospital (institutional) level. Such a change is deemed desirable, as it will permit better control of specialty programs. It remains to be seen whether institutions will base the apportionment of residency positions on national and local manpower needs as well as service needs. In the authors' judgment, it seems probable that the specialty programs emphasized by a particular institution will mirror that institution's unique strengths, regardless of perceived health manpower needs.

At present, residency training programs are accredited by the LCGME, upon recommendation of the appropriate Residency Review Committee (RRC). Despite the fact that some factions in the RRCs and the LCGME, or its parent bodies, are opposed to them,²¹ the proposed general requirements may strengthen the authority of the RRCs to obtain compliance with their particular special requirements. For example, a major section of the proposed general requirements entitled "Program Organization and Responsibilities," delineates responsibilities at the program level regarding: (1) goals; (2) qualifications and responsibilities of program directors; and (3) requirements for institutional support of program directors.²⁰

One of the major objections to the proposed general requirements is concern that this may represent the first step toward institutional accreditation for graduate medical education, similar to what we presently have for undergraduate medical education. In this case, accredited institutions could establish residency programs in any specialties they desired. In the opinion of the present authors, institutional accreditation of graduate medical education does not appear imminent, based upon its present stage of development.

References

1. American Medical Association. Medical Education in the United States 1977-1978. *JAMA* 240:2820, 1978.
2. Stevens, RA: Graduate medical education: A continuing history. *J Med Educ* 53:1-18, 1978.
3. Flexner, A: Medical education in the United States and Canada: A report to the Carnegie Foundation for the Advancement of Teaching. Merrymount Press, Boston 1910, 20-29.

4. Cambridge Research Institute. Trends Affecting the U.S. Health Care System. Prepared by Cambridge Research Institute for U.S. Dept. of Health, Education, and Welfare. Rockville, Maryland: U.S. Dept. of Health, Education, and Welfare, Health Resources Administration, Bureau of Health Planning and Resources Development. U.S. Govt. Print. Off. 1976. Health Planning information series: 1. DHEW publication No. HRA76-14503, pp 91-95.
5. Coordinating Council on Medical Education. Physician Manpower and Distribution: The Role of the Foreign Medical Graduate, June 1976.
6. Department of Health, Education, and Welfare, Public Health Service. Health Professions Educational Assistance Act, 1976; Direct and Affiliated Medical Residency Program Data Section 771(6)(2) Federal Register 42:59582-59583, November 18, 1977.
7. Bunker, JP: Surgical manpower: A comparison of operations and surgeons in the United States and in England and in Wales. *New Engl J Med* 282:135-144, 1970.
8. Axelrod, SJ, Donabedian, A, Gentry, DW: *Medical Care Chartbook* 6th ed Ann Arbor, Michigan: University of Michigan, School of Public Health, Dept. of Medical Care Organization, Bureau of Public Health Economics, 1976.
9. Schonfeld, HK, Heston, JF, Falk, IS: Numbers of physicians required for primary medical care. *N Engl J Med* 286: 571-576, 1972.
10. American Medical Association Report of the Ad Hoc Committee on Education for Family Practice. *Meeting the Challenge of Family Practice* Chicago, Illinois: American Medical Association, Sept. 1966, p 7.
11. Millis, JS. A rational public policy for medical education and its financing: A report to the Board of Directors, the National Fund for Medical Education. Cleveland, 1971, p 33.
12. McGinnis, JM: Improving access to health care: Incentives, regulations, or substitutions? *J Med Educ* 52:691-693, 1977.
13. Scheffler, RM, Weisfeld, N, Ruby, G, et al: A manpower policy for primary health care. *New Engl J Med* 298: 1058-1062, 1978.
14. Morrow, JH, Edward, AB: US health manpower policy: Will the benefits justify the costs? *J Med Educ* 51:791-805, 1976.
15. Geyman, JP: How many family physicians are needed? *J Fam Pract* 7:257-258, 1978.
16. American Medical Association. Medical education in the United States 1977-1978. *JAMA* 240:2802-2910, 1978.
17. American Medical Association. Essentials of accredited residencies, 1978-1979 directory of residency training programs, Chicago, Ill., 1978, p 11.
18. Interim Report of the Graduate Medical Education National Advisory Committee, DHEW publication No. (HRA) 79-633, 1979.
19. American Medical Association. Citizens Commission Report on Graduate Medical Education. The Graduate Education of Physicians, Chicago, Illinois: American Medical Association, 1966.
20. The Essentials of Accredited Residencies in Graduate Medical Education. Proposed revision, distributed by the Association of American Medical Colleges, 1979.
21. Association of American Medical Colleges. Weekly Report No. 78-39, Nov. 21, 1978. ☆☆☆

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PHYSICIAN'S GUIDE TO OHIO LAW

Response to the "PHYSICIAN'S GUIDE TO OHIO LAW," recently published by the OSMA Department of State and Federal Legislation, has been outstanding. Numerous copies of the 28-page booklet have been requested by physicians and various individuals and groups throughout the State. The booklet is "intended to alert physicians to Ohio law affecting certain aspects of their practice." Requests for ten (10) or fewer copies of the booklet will be provided free of charge to OSMA members; additional copies will be mailed to OSMA members at a charge of 50¢ per copy. Similarly, copies will be provided to non-OSMA members at a charge of 50¢ per copy, plus mailing costs.

As a lame-duck legislature, the 113th Ohio General Assembly returns this month for the final weeks of the current biennial session. The session began on January 1, 1979, and must end by December 31, 1980. With a freshly elected membership, the 114th Ohio General Assembly will convene in January, 1981.

Below is a list, and a brief description, of bills that are in various positions within the legislative process. These bills are selected from more than 200 that have been followed by the OSMA this session. They are included here on the basis of (1) their priority to the OSMA, and (2) the possibility that some form of legislative action might be taken during the next few weeks.

Please be advised that this list is by no means all-inclusive. Strange things tend to occur during lame-duck sessions. Unfortunately, until the legislature adjourns "sine die," just about anything can happen.

HOUSE BILL 16 - (J. Thompson, D-Cleveland) - PHYSICIAN'S ASSISTANTS

HB 16 provides for institutional hiring of physician's assistants. Under current law, a PA may provide services only to patients of the physician with whom the PA is employed. Under HB 16, hospitals, nursing homes, and other "institutions" could employ PA directly. The bill fails to provide adequate safeguards for the supervision of, and responsibility for, PAs who might be employed by the institutions. The OSMA opposes HB 16, which stands before a subcommittee of the Senate Education and Health Committee.

HOUSE BILLS 210/211 - (L. Brown, D-Columbus) - PHYSICAL THERAPY

HB 210 is before a subcommittee of the House Small and General Business Committee. One hearing has been held. The two bills, drafted by the Ohio Chapter of the American Physical Therapy Association, would (1) add physical therapists to the list of "professionals" in the Revised Code, thereby allowing them to offer physical therapy services through professional corporations, and (2) require hospitals to review and accept physical therapists' applications for staff membership and/or privileges. Subcommittee Chairman Larry Christman (D-Englewood) has postponed further hearings until he has received "satisfactory" an-

swers to several legal questions raised by the OSMA and the OHA in testimony. OSMA opposes the bills as drafted.

HOUSE BILL 554 - (Corbin, R-Dayton) - HOME HEALTH CARE LICENSURE

HB 554 establishes a structure of standards and a procedure for annual licensure for home health care agencies. The bill passed the House and is before the Senate Education and Health Committee, where it has stalled in a dispute between proprietary agencies and a coalition which includes Health Systems Agencies, the Ohio Department of Health, and not-for-profit and public agencies. The dispute focuses on the question of whether home health care agencies should fall under Certificate of Need requirements. As reported from subcommittee, the bill contains OSMA-suggested amendments requiring physician control of medical services.

HOUSE BILL 636 - (Zehner, D-Yellow Springs) - TRUTH IN TESTING

HB 636, patterned after a New York law, requires any agency administering a standardized test for educational admission to file with the Board of Regents copies of the test and answers, as well as background statistical information. In addition, any person who has taken a test could obtain his or her answer sheet from the agency after 180 days from the test date. The bill is before a subcommittee of the House Education Committee. The sponsor has been receptive to OSMA suggestions that medical admission tests be exempted from the bill's provisions. OSMA opposes the present draft of HB 636.

SENATE BILL 368 - (Roberto, D-Ravenna) - STATE MEDICAL BOARD REVISIONS

SB 368, which passed the Senate unanimously, is pending before the House Rules Committee, awaiting scheduling for a floor vote. The bill increases the investigative/enforcement authority of the Board, and includes an OSMA amendment that requires the Board to accept a simple "certification" of CME hours rather than the current cumbersome requirement for mailing CME log books to the Board. This certification procedure, which is comparable to the certification which an individual makes when filing tax forms with the IRS, should eliminate a great deal of red tape for physicians and the Board itself. If the bill is enacted, the Board will spot-check physicians randomly for verification of CME hours. Therefore, physicians would still have to retain CME records.

Under SB 368, the existing triennial registration program is replaced with a biennial program, beginning in 1983. Registration (renewal) fees, which are currently \$50 triennially, would be \$100 biennially. With the increased budget, the Board intends to place additional investigators throughout the state.

The bill adds an additional consumer member to the Board and standardizes the length of term for Board members to five years. Currently, MD and podiatrist members

serve seven-year terms, while DO and consumer members serve four-year terms.

The bill grants the board the authority to subpoena during the course of investigations. In addition, the Board is authorized in emergency situations to take disciplinary action against a practitioner without a hearing, if the health of the public is endangered and as long as a hearing is held within fifteen days. A similar Florida statute has been challenged as infringing on due process rights of physicians. That statute was upheld.

Finally, several provisions were included within SB 368 with the intention of streamlining the process of appeals of Board actions.

EMERGENCY MEDICAL SERVICES LEGISLATION

The OSMA is working with the Governor's Advisory Committee on Emergency Medicine and other interested groups to develop new EMS legislation. The OSMA Committee on Emergency Medicine, the OSMA Committee on State Legislation, and the Council will then review and comment on the proposals. This omnibus legislation will be introduced early next session by Rep. Rocco Colonna (D-Brook Park). The goal is to upgrade EMS services across Ohio, eliminate bureaucratic overlap and duplication, and attract available Federal dollars. It is hoped that many differences among interested groups will be worked out before introduction next winter.

HOUSE BILL 753 - (J. Thompson, D-Cleveland) - HOSPITAL LICENSURE

Another licensing proposal, HB 753 adopts the standards of the Joint Commission on the Accreditation of Hospitals (JCAH) as the Ohio standards for hospital licensure. JCAH accreditation of a hospital would give rise to a presumption of compliance with Ohio licensing standards without further inspection.

HB 753 contains a critical OSMA-proposed amendment requiring that all patients be admitted to a hospital by a physician or dentist and that all patients must be under the medical supervision of a physician. This amendment was proposed in response to an intensive lobbying effort by the Ohio Psychological Association to gain hospital admitting privileges for psychologists by statute.

The Ohio Psychological Association continues to push for admitting privileges for psychologists in the bill. The OSMA supports the bill, as long as the supervision and admission requirements remain as presently drafted, and is pushing for hearings on the measure.

HOUSE BILL 768 - (Locker, D-Anna) - RADIATION SHIPMENTS

As introduced, the bill would have affected certain physicians, as it regulated shipments of Type A, Type B, and large quantities of radioactive materials. Type A and Type B quantities were deleted from the bill, which gives the Director of the Environmental Protection Agency the authority to require permits for any shipments of large quantities of radioactive materials within the state. The bill passed the House and is before the Senate Energy and Public Utilities Committee.

HOUSE BILL 879 - (Rocco, D-Parma) - ABORTION

HB 879 establishes new informed consent requirements for abortion and creates new regulations for abortion facilities. The bill has had several hearings before a subcommittee of the House Judiciary Committee. OSMA has no position on enactment of HB 879, but has recommended a few changes in the present draft.

HOUSE BILL 1029 - (Orlett, D-Dayton) - EXPANSION OF NURSING PRACTICE

HB 1029 was drafted by the Ohio Nurses Association to change the definition of the practice of nursing, to delete the utilization of interim nursing permits, and to increase the authority of the State Board of Nursing.

Nurses who oppose HB 1029 claim the bill is a first step in an ONA effort to phase out all categories of nursing other than RNs. Massive opposition by these nurses has delayed further action on the bill. The OSMA opposes the bill because of the definition of the "practice of nursing" in the measure, which contains no clear prohibition against acts of medical diagnosis or prescription of medical, therapeutic, or corrective medical measures.

HOUSE BILL 1085 - (Gilmore, R-Columbus) - DETERMINATION OF DEATH

The bill would establish a statutory definition of death in Ohio and provide for living wills. The definition of death does not include brain death. The OSMA has provided extensive information to the House Judiciary Committee on medical and legal standards for the determination of death, both the traditional cardiorespiratory criteria and the criteria for the determination of brain death. The new OSMA position on determination of death has been expressed to the members of the Committee. OSMA is monitoring this bill closely. The OSMA will sponsor legislation on this subject in 1981 pursuant to House of Delegates resolutions.

SENATE BILL 359 - (Butts, D-Cleveland) - MEDICAL DISCRIMINATION

SB 359 prohibits a physician from (1) asking a patient if he/she is eligible for Medicare, (2) refusing to accept a patient because he/she is eligible for Medicare, and (3) charging a Medicare patient in excess of U.C.R. The bill involves civil liability and fines for violation of these three provisions, and has been assigned to the Senate Commerce and Labor Committee but has not had any hearings. OSMA opposes SB 359.

SENATE BILL 231 - (Valiquette, D-Toledo) - MANDATORY HOSPITAL COST CONTAINMENT

SB 231 is in a subcommittee of the Senate Insurance Committee. It establishes specific mandatory hospital cost containment requirements on Blue Cross and their subscriber hospitals. A major concern of the OSMA is the proposed utilization review requirements that ultimately could remove local physician input in review of physician services.

Features

Something Intangible 661

William H. Havener, M.D.

The author explains the importance of "reassurance therapy" and how it can be delivered by your office staff.

AMA-ERF:

Supporting Medicine's

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Robert D. Clinger

A look at how your contributions to the AMA's Education and Research Fund can be put to work.

A Word of Advice 667

James Pohlman and Ralph Preston

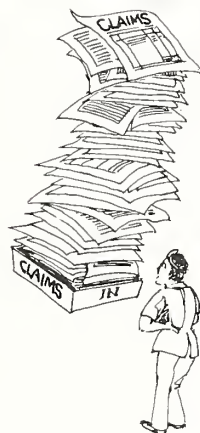
The authors, both attorneys, offer some legal advice on how to report the recently returned stabilization reserve fund monies on your federal income tax.

Third-Party Payers Section 669

This special section of the *Journal* begins a series of articles which will take an in-depth look at third-party payers, and how to understand their various systems. This month, an overview of third-party payers is presented, along with a detailed look at Medicare.



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Special Section:
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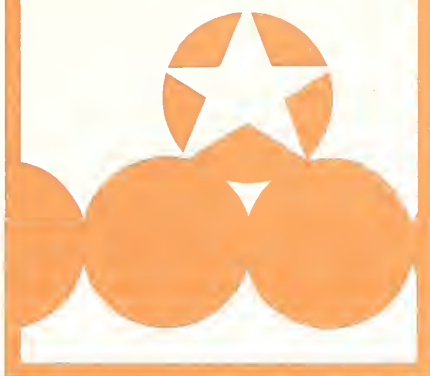
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COLLEAGUES IN THE NEWS



ROMEO T. BACHAND, JR., M.D., Painesville, was named flight surgeon for the U.S. Air Force Reserves 910th Tactical Air Command based at Youngstown Municipal Airport.

ROBERT BOWMAN, M.D., Cleveland, was honored for 30 years of volunteer service in Booth Memorial Hospital's Maternity Home Program.

HARRY CHOVNICK, M.D., Jackson County, is permanent medical director of the Gallia-Jackson-Meigs Community Mental Health Center.

FOSTER J. BOYD, M.D., Mt. Orab, was elected to the 66-member board of trustees of the American Cancer Society, Ohio Division, Inc.

STANLEY M. GOODMAN, M.D., Fairfield, was appointed to the advisory board to develop residential and nonresidential programs for delinquent youths in Butler County.

ALFORD C. DILLER, M.D., Van Wert, was elected for a one-year term as chairman of the State Health Coordinating Council. SHCC, a 67-member body composed of consumers and providers of health care, is responsible for coordinating health planning for the State of Ohio.

Dr. Diller also serves as councilor from the Third District.

JAMES HART, M.D., Bucyrus, was appointed director of blood services with the American Red Cross, Central Ohio Region.



Alford C. Diller, M.D. . . . chairing the State Health Coordinating Council.



Tennyson Williams, M.D. . . . new president-elect.

MARK R. LEVINE, M.D., Cleveland, was named chief of the division of ophthalmology at Mt. Sinai Hospital. Dr. Levine is an assistant clinical professor at Case Western Reserve University's School of Medicine.

FRANK R. NOYES, M.D., Cincinnati, was appointed to the board of directors of the American Academy of Orthopedic Surgeons. Dr. Noyes is professor of orthopedic surgery and director of the University of Cincinnati Sports Medicine Institute.

JOSEPH PROVENZANO, M.D., Toledo, was named family physician of the year by the Ohio Academy of Family Physicians.

OLIVER K. ROTH, M.D., Cincinnati, was installed as president of the Ohio Academy of Family Physicians.

Other officers installed include: **TENNYSON WILLIAMS, M.D.,** Dublin, president-elect; **RAYMOND A. KIWALA, M.D.,** Cleveland, vice-president; and **THOMAS U. TODD, M.D.,** Cincinnati, treasurer.

Officers elected by the medical staff of McCullough-Hyde Memorial Hospital, Oxford, include: **WILLIAM STITT, M.D.,** chief of staff; **THOMAS GLYNN, M.D.,** secretary-treasurer; and **THOMAS HUGHES, M.D.,** vice chief of staff.

CHI HONG YANG, M.D., Crestline, was reappointed as physician for Fairview Manor residents for a one-year period. Dr. Yang has served as the Fairview Manor physician for the past four years.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Karen S. Edwards**

\$3 Billion saved

Urging more involvement by state governments in the Voluntary Effort to Contain Health Care Costs, AMA Board of Trustees Chairman Lowell H. Steen, M.D., told the nation's governors at the Annual Meeting of the National Governors' Assn. that the VE was instrumental in saving consumers about \$3 billion in 1978-1979. In a letter addressed to each governor before the meeting, the AMA called for further consideration of a proposed National Governors' Assn. policy statement that would encourage states to contract with exclusive providers under Medicaid. The AMA offered to work with the NGA on positive actions to help reduce Medicaid expenditures without restricting the patient's freedom of choice.

Blue Shield launches "Consult II" program

Editor's Note: The following article is presented at the request of Ohio Medical Indemnity Mutual Corporation (OMIM) in an effort to inform physicians about a new program sponsored by OMIM. The article is presented as information only and does not necessarily represent endorsement of the program by OSMA.

A new cost-containment program, enabling more than 3.5 million Ohio Blue Shield subscribers to obtain payment for a second opinion regarding elective surgery, became effective September 4.

The program, called Consult II, will be provided to subscribers who have a medical and surgical health insurance contract with Ohio Medical Indemnity Mutual Corporation (OMIM). The program also will pay for a third medical opinion if it is needed.

The program begins after patients have had an initial recommendation for nonemergency surgery from their primary physician. Facing the possibility of surgery, patients may seek a second opinion to help them further understand the medical procedure ahead of them. By calling a toll-free telephone number to Blue Shield's office in Worthington, they will be provided with names of physicians in their area who have agreed to support the program as voluntary consultants. From those names, patients may choose a consultant and make their own appointment.

If the second opinion differs from that of the primary physician, Blue Shield will pay for a third consultation, if patients wish to obtain one.

Blue Shield emphasizes that physician support throughout Ohio is critical to the success of Consult II. General practitioners and specialists in many fields are needed to serve as second-opinion consultants, and will

be reimbursed directly by Blue Shield for consultation services at the Usual, Customary and Reasonable (UCR) benefit level.

Supporting consultants are asked to agree to the following:

- to provide a second opinion, in a timely manner, on the initially recommended surgery;
- to relate this opinion personally to the patient;
- to provide a recommendation on the appropriate site of services, ie, hospital inpatient, outpatient, physician's office, clinic, etc.;
- to complete a consultant's report indicating the results of the second opinion and forward claim materials to Blue Shield for reimbursement;
- to agree not to assume care of the patient for the specific medical condition which resulted in the request for the second opinion;
- to agree not to contact the patient's primary physician without the patient's permission; and
- to rely on existing laboratory and X-ray reports when available, and to repeat or perform additional diagnostic tests only when necessary. (Payment also is made for the ancillary diagnostic services which are necessary to help the consultant determine the patient's medical condition.)

To become a supporting consultant in the second-opinion program, or to obtain more information, please contact your local Blue Shield Professional Relations representative, or call John Micha at (614) 438-3574.



Celibacy and pro sports: Is it play now, pay later?

When the Minnesota Vikings played the Pittsburgh Steelers in Super Bowl X, the Minnesota Vikings were sequestered from their wives for several days.

The Steelers were allowed to spend the night before the game with their wives in their hotel rooms.

The Vikings proved no match for the Steelers, losing 16-6.

While the outcome of the game was decided by the superiority of the Steelers, the object lesson learned, according to Dr. Donald L. Cooper, Director of the Oklahoma State University Hospital and Clinic in Stillwater, and team physician for the

Big Eight conference representatives, was that having sex before the Big Game had absolutely no effect on the eventual outcome.

The idea of not engaging in sexual activity because it will take away from an athlete's performance "is one of the many sports myths that has crept into our society and has been around so long, it is widely accepted as truth," Dr. Cooper said.

"Most team physicians that I have visited with feel that a normal pattern of sexual practice is not detrimental as long as a proper amount of sleep is obtained," Dr. Cooper adds.

Vitamin C and glucose testing

A study of the effect of various dosages of vitamin C on glucose testing was the subject of a science fair exhibit which took its Columbus student exhibitor all the way to the AMA convention in Chicago last July.

Penny Wamsley, a recent graduate of Whitehall-Yearling High School in Columbus, originated the project which garnered local, regional, and international science fair honors before the invitation to the AMA Convention came along, one of only two such invitations extended.

For background information for her exhibit, Miss Wamsley drew from essays she found in the Ohio State University medical library, which detailed experiments conducted in the Netherlands on vitamin C and its effects on glucose testing.

Miss Wamsley's own findings show that vitamin C does cause interference in glucose testing, producing a negative reaction the same way that glucose in the urine would produce a negative reaction.

In an experiment which she conducted as part of last year's science fair, Miss Wamsley determined that high-protein diets also can affect glucose testing with false negative reactions.

MISCELLANEA

• "Bobby," a recently released free-loan film, describes the relationship between a hyperactive youngster and his family and friends. This 16 mm color film, which runs 25 minutes, stresses the important roles of time, understanding, and professional guidance in helping children with short attention spans and hyperkinetic behavior patterns reach their potential. "Bobby" can be ordered on free-loan from Abbott Laboratories Audio-Visual Services, 565 Fifth Ave., New York, New York 10017. When ordering, please specify preferred and alternate show dates.

The revised version of the AMA *Manual on Alcoholism* gives a current authoritative overview of the major considerations involved in helping patients with alcohol problems. This edition incorporates a major portion of

a previous AMA publication — *Medical Complications of Alcohol Abuse*. Cost of the *Manual* (OP-185) is \$2.50 each for 1-10 copies; \$2.25 each for 11-49; and \$2 each for 50 or more. Write AMA Order Dept., P.O. Box 821, Monroe, Wis. 53566.

• Private health insuring organizations paid **\$50.8 billion in benefits** in 1978, according to the Health Insurance Institute. That was a 17.8 percent increase over 1977, more than the percentage increase in medical costs during the year, and more than four times the amount paid ten years earlier. As reported in the 1979-1980 edition of the "Source Book of Health Insurance Data," the increase was due mainly to the rising cost of medical care, expansion of benefits and higher utilization.

Clinical trials urged for THC use

Research on the use of THC, the active ingredient in marijuana, to reduce nausea due to chemotherapy should be pursued in broader clinical trials with cancer patients, the AMA said in a letter to the FDA's Oncology Advisory Committee. The Association commended the efforts to bring "some hope of relief from the mentally and physically debilitating side effects of cancer chemotherapy," and offered assistance with expanded clinical trials. However, the letter urged continued stringent controls to avoid illicit use of the drug.

PICO introduces coverage for residents, young physicians

Physicians Insurance Company of Ohio (PICO) recently initiated a program of medical professional liability coverages for residents and physicians in their first two years of practice. The program has been developed in direct response to a resolution of the 1980 OSMA House of Delegates.

Young doctors can now obtain PICO's occurrence medical professional liability coverage at substantial discounts. Residents can obtain limits of either \$100,000/\$300,000 or \$200,000/\$600,000 for 25% of the usual charge for PICO's lowest risk classification. The average premium charge under this new plan for residents will be in the range of \$200-\$300. This new type of policy takes the form of "excess" over any other primary coverage the resident may already possess. If the doctor does not have applicable coverage, then this would become the primary protection.

For the first- and second-year newly practicing physicians, PICO is now offering occurrence coverage at substantial discounts. The main purpose of these low rates is to help new doctors in their first years when they are incurring the costs associated with starting a practice.

First-year practitioners can obtain the limits mentioned above, as well as \$1 million excess, for 35% of the usual charge for their applicable risk classifications. In their second year of practice, young doctors pay 70% of the usual charge. PICO's full premium charges do not apply until the physician's third year of practice.

However, physicians must be OSMA members (and therefore, members of their local societies) to be eligible. (This is true of all PICO coverages).

For more information, please call your local PICO agent, or the home office at 1-800-282-7515 or (614) 864-7100.

BOOK SHELF

"Retirement Plans — Economic Bliss or Fiscal Disaster?" is a 20-page report, prepared by Salt Lake City attorney James R. Baker, on the benefits and advantages of various retirement programs and the efficiency of each as a tax shelter.

Prepared especially for physicians, the report is illustrated with case histories to show the flexibility of various plans and the amounts of money that can be sheltered by the doctor.

For a free copy, write to James R. Baker, P.C., 22 Hillside Avenue, Salt Lake City, Utah 84103.



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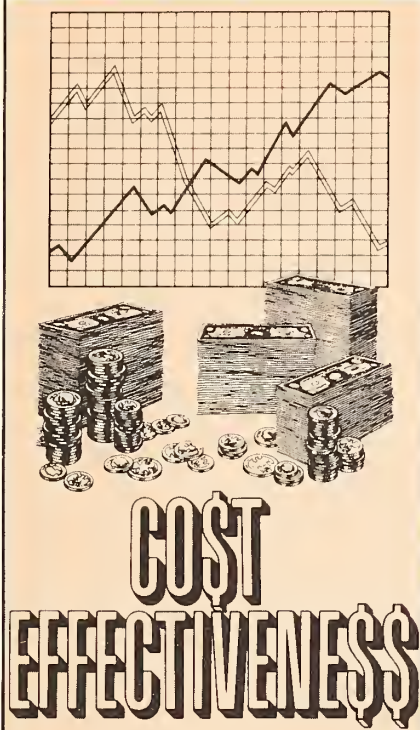
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Cost awareness in continuing medical education: an experiment

Moham L. Garg, Sc.D.

Warren M. Kleinberg, M.D.

Werner A. Gleibe, M.A.

The Department of Cost Containment and Evaluation at the Medical College of Ohio has developed an educational program for practicing physicians entitled the Northwest Ohio Cost Awareness Project (NOCAP). NOCAP attempts to teach cost awareness through selected methods in as many hospitals as possible in Northwest Ohio. With the support of the Ohio State Medical Association (OSMA), and funding from the National Fund for Medical Education (NFME), it demonstrates that physicians are just as concerned as the public and the government about soaring health-care costs and are actively trying to do something about them.

The goals of NOCAP are to demonstrate the truth of the statement that "cost awareness begins at home," and can be done effectively. NOCAP seeks to develop, test, and evaluate several cost-awareness methodologies that can be readily integrated into existing educational programs in the twenty-county region of Northwest Ohio. A second goal is to provide some empirical assessment of the impact of such programs on patient care. Despite proliferation of CME activities, and the resources expended to provide these programs, little evidence is available that demonstrates empirically the presumed relationship between CME and physician practice performance. Some evidence on this matter would be a major contribution to elaboration of a sound public policy toward CME programs. A third long-term goal of the project is to create cost-awareness programs that, with the support of OSMA, can be implemented in CME programs throughout the state.

Program Implementation

The hospitals in the Northwest Ohio region serve as primary contacts for planning and implementing cost-awareness educational programs. All interested hospitals are invited to participate. The program is designed to best meet the needs of the particular hospital. Where none exist and interest is shown, programs may

be prepared for staff meetings of the particular hospitals. Presentations describing this approach might also be made at meetings of county medical societies if that is found to be a suitable forum.

Regional planning meetings to determine the needs of physicians and hospital educational programs are held periodically. The meetings with local hospitals seek active support for their participation in some type of educational or informational activities about cost-awareness concepts. Approaches ultimately taken at these sites depend on their specific needs and interests.

Available Options

Three alternative types of involvement are currently available to the cooperating hospital. Two options are derived from results of a medical-care evaluation (MCE) study, conducted in the hospital.

Option A presents the cost analyses through special programs to the medical staff. Other additional sessions can be presented as necessary. The programs are evaluated in two ways, by the audience at the presentation, and by a later MCE.

Option B uses the results of the MCE to present special topical programs with cost components included. Such programs will also be evaluated as above.

Option C integrates cost-awareness concepts into traditional educational techniques: case presentations (including clinical-pathological conferences) and topical presentations.

A traditional method of teaching medicine, the clinical-pathological conference (CPC) consists of a case history with subjective and objective findings on the day of admission, important diagnostic work-up and results, differential diagnosis, clinical diagnosis, and pathology analysis. The revised CPC, developed and implemented at the undergraduate medical education level at the Medical College of Ohio with earlier NFME funds, consists of four parts: 1) the general description of the case with subjective and objective findings on

the day of admission, 2) the patient progress summary for each day divided into subjective and objective findings with space for assessment, 3) daily treatment schedule, and 4) daily compilation of diagnostic tests ordered, their charges and their usefulness in diagnosis and management. The revised CPC adheres to traditional formats and poses five fundamental questions: What was done? At what stage? Why? Was it necessary? Was it effective? These five questions offer a challenge to each decision in the management plan, and require a knowledge of the course and outcome of the process. The methodology is significant since it can be used as an educational tool at all levels of medical education.

Anticipated Effects

NOCAP will create a regionwide set of community physicians proficient in the integration of cost-awareness objectives into their traditional CME activities. They will represent a substantial new pool of cost-awareness teachers among community physicians who would form the nucleus of a long-

term, competent CME faculty. Another desirable outcome is the evaluation of the effects of these cost-awareness educational programs.

Meetings will be held periodically with the planning group bringing together representatives of all participating hospitals. Experiences can be shared and plans or suggestions for improvements can be made. With appropriate assessment and organization, the regional experiences can then be shared regularly at the state level.

For the 1,500 practicing physicians in Northwest Ohio, cost awareness must come through regularly scheduled educational activities at the local, regional, and state levels. In light of the current Ohio state law requiring 150 CME credits for relicensure every three years, an opportunity exists for the provider sector to help in the struggle to contain health-care costs through its CME program. If cost-awareness concepts are effectively integrated into CME activities, and sanctioned by medical societies, part of the long-term impact of Ohio's "voluntary effort" to

contain costs can be assessed.

NOCAP will result in a significant number of practicing physicians exposed to medical care cost issues. The project also will increase the pool of community physician educators who are familiar with the know-how to present cost-awareness concepts in ongoing educational activities. Other professional organizations will hopefully support NOCAP by creating various forums for public dissemination of the project's progress.

The quantifiable nature of cost knowledge, coupled with increasing public pressures to "do something," make this an appropriate historical moment to implement this experiment. The NOCAP is the first attempt of its kind in the country. If it succeeds, it will demonstrate to all interested parties that physicians are concerned about high health-care costs and, to the extent that they can, are trying to make a difference. The spirit of the "voluntary effort" is at the heart of the project. Hopefully, the government will recognize the innovative approaches of the private sector toward ends contributing to the public good. **OSMA**

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Something Intangible

By William H. Havener, M.D.

Editor's note: The following article is based on a series of guidelines which the author presents to newly hired medical office employees.

Besides telling the employee about the tangible things that will be expected of him or her, the guidelines go one step further

and relate the intangible qualities of a good medical office staff.

The Journal felt that OSMA members might be interested in this novel approach, and perhaps find the guidelines adaptable for their own office personnel.

As a secretary in a medical office, what do we, the physician and patients, need from you? The tangibles are always mentioned — properly filled out insurance forms, no typing errors, pleasant phone manners, neat professional appearance. However, there is something else, something intangible — something we will call “reassurance therapy.”

Reassurance therapy deals with the emotions, not the body, and it can cure or greatly benefit one third of all patients who seek our help, for it helps to relieve the uneasiness that accompanies disease.

However, we are not talking about something simplistic. Learning to give reassurance therapy is not easy. It involves thinking, working and observing. Of necessity, when you first come to the office, everything is new and unfamiliar but in doing and learning you become a teammate with the physician. Ask the physician questions, delve deeply, read, listen to him or her talk to the patients. Certain

steps must be taken to remedy the problems brought to you by patients. The goal of the teammates is to perform the required steps effectively and promptly, thereby meeting the patient's needs.

There are six steps in reassuring the patient. The physician must perform these six steps, or the patient will not be reassured, will not follow instructions, will not return, and will not be helped. As you gain knowledge and skill, you can become a teammate in performing these six steps.

Step One — History

One purpose of a medical history is to elicit details of the patient's problem sufficiently to identify its location. “Elicit” does not mean just listening to the patient. It means thinking about the complaints, deciding what they signify, and asking relevant questions to confirm or deny your suppositions as to what is the problem.

In taking a history, write down the

complaints as accurately as possible. Taking a history is a challenge, but it develops a rapport between you and the patients, and from the patient's standpoint, it is step one of their reassurance. As you listen to the patient's history, you can sense how important he or she considers the process to be, as seemingly irrelevant details are given in hope that you can derive some meaning that will help. By allowing the patient to talk in such detail, he or she derives a sense of emotional satisfaction in communicating the problem.

Step Two — Evaluation of Affect

“Affect” is the emotional impact of the problem upon the patient, and as such an emotional impact occurs, it adds to the handicap of the physical disease that is present. Both emotional and physical problems must be treated. The physical problems are treated by surgery and medication; the

emotional problems by reassurance therapy.

If you have taken the history, you can now provide some beginning reassurance. You can make some short-term predictions by explaining routine details to the patient such as where to go, what to do, and when the physician will see him or her. This is the beginning of the "credible prediction of the future," which is reassurance therapy. If you find a patient in need of reassurance, write it on the chart or otherwise let the physician know. In later steps, you can deliver more reassurance yourself.

Step Three — Physical Examination

The affected part must be examined by the physician with sufficient thoroughness to confirm or deny suspicions aroused by the history, to obtain information relevant to his decisions, and to exclude the presence of other important disorders.

Step Four — Medical Diagnosis

What is wrong with me? Does this physician know? These are the questions the patient asks, and the physician must convey the impression that he knows what is wrong by words, actions, or both.

Step Five — Explanation

Some factual information must be explained to the patient. Enough is required so that he or she can make a reasonable decision about his or her own health. More importantly, by actions and words, three emotional beliefs must be transmitted to the patient: the physician (1) understands the symptoms, (2) understands the management of the problems, and (3) wants to help the patient.

The patient accepts you as the physician's teammate and your actions or words contribute to the patient's confidence or doubts. The better you are able to do your part, the more effective will be the reassurance. What

you might consider routine matters are sometimes very important to the patient.

Step Six — Reassurance

Effective reassurance can occur only after the first five steps: history, evaluation of affect, physical examination, medical diagnosis, and explanation. The sixth step is reassurance. It will not work if you skip any of the other steps — but you can reassure a patient, no matter how skeptical of that fact you might be.

After all, you can predict the future convincingly. You know the dates of appointments, the location of the hospital, the time of surgery. All these seemingly trivial details make up the fabric of life, the hope for the future to which the patient must cling. **OSMA**

William H. Havener, M.D., is an ophthalmologist practicing in Columbus, Ohio.

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AMA-ERF: SUPPORTING MEDICINE'S FUTURE

By Robert D. Clinger

Each year, Ohio physicians and their spouses provide strong financial support to the American Medical Association Education and Research Foundation (AMA-ERF).

Once again, you and your spouse have the opportunity to contribute to this most worthwhile program. Nationwide, approximately two thirds of the AMA-ERF contributions come from concerned physicians and through the untiring efforts of auxiliary fund-raising programs.

Shortly after this issue of the *Ohio State Medical Journal* is mailed, you will receive an AMA-ERF contribution envelope and a letter from Ohio AMA-ERF Committee Chairman, Philip B. Hardymon, M.D.

Five options for your AMA-ERF contribution are listed on the back cover of the envelope. Please mark your choice and check the amount prior to sealing. The options are as follows:

- Funds for AMA-Approved Medical Schools (designated or undesignated)
- AMA-ERF Medical Education Loan Guarantee Program
- AMA-ERF Unrestricted Fund
- AMA-ERF Deserving Disadvantaged Medical Student Loan Plan
- AMA-ERF Special Research Grants

The preaddressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

Please note that your contribution is tax deductible. AMA-ERF is classified by the Internal Revenue Service as a "501(c)(3)" organization. Gifts are regarded as charitable contributions to a public foundation. They are deductible up to 50 percent of adjusted gross income computed without regard to any net operating loss carryback.

Funds for AMA-Approved Medical Schools (Designated or Undesignated)

You can either designate a medical school to receive the amount of your contribution in your name — or contribute to an undesignated fund. Monies from the latter are divided equally among all AMA-approved schools.

These funds are used by each school for a variety of purposes such as providing students with financial means to finish their medical education, building improvements, faculty salaries, etc.

Medical schools gain two important financial advantages through AMA-ERF donations:

1. The school may use the money to best suit its needs. However, if you wish to designate a specific use for your gift, your wish will be honored if at all possible.
2. AMA-ERF absorbs the expenses a school would normally incur when soliciting its own funds.

During 1979, designated and undesignated grants to Ohio's medical schools totaled \$62,553.29 (see Table 1). Total contributions to all AMA-approved medical schools in 1979 amounted to \$1,180,000.

Since 1976, the Ohio medical schools have received a total of \$262,272.38 (see Table 2).

AMA-ERF Medical Education Loan Guarantee Program

This program was suspended in the spring of 1980 in response to credit curtailing reserve requirements imposed by the Federal Reserve Board. Even though the requirements were subsequently withdrawn, participating banks evaluated their participation. The general conclusion was that long-term, fixed-rate loans, saddled with rising money costs and inflation, are unattractive to the banks.

AMA-ERF officials point out that contributions for the loan program continue to be welcome. The program may be able to serve effectively again

Table 1

AMA-ERF Grants To Ohio Medical Schools *1980

Case Western Reserve School of Medicine	\$11,373.71
University of Cincinnati College of Medicine	\$16,586.37
Medical College of Ohio at Toledo	\$ 5,116.50
Northeastern Ohio Universities College of Medicine	\$ 4,554.25
The Ohio State University College of Medicine	\$20,159.01
Wright State University School of Medicine	\$ 4,763.45
TOTAL	\$62,553.29

*From contributions during 1979. Checks presented at 1980 OSMA Annual Meeting.

in the future when the economy improves.

AMA-ERF Unrestricted Fund

This is a flexible fund, applied at the discretion of the Foundation's Board of Directors, to support special health and medical programs, and to provide emergency grants.

It has provided seed monies for health education programs. Its funds also have been used to develop prototype school health screening and nutritional programs for the poor. Its funds also support a program in which the Ohio State Medical Association is actively participating — the AMA Program to Improve Medical Care and Health Services in Correctional Institutions.

AMA-ERF Deserving Disadvantaged Medical Student Loan Plan

This plan was launched in a few states on an experimental basis in the early 1970s. New loans have been curtailed, but contributions are needed in order to support students currently under this Plan.

Table 2

AMA-ERF Grants To Ohio Medical Schools 1976 - 1980

Case Western Reserve School of Medicine	\$ 42,909.10
University of Cincinnati College of Medicine	\$ 70,018.93
Medical College of Ohio at Toledo	\$ 23,365.25
Northeastern Ohio Universities College of Medicine	\$ 22,966.33
The Ohio State University College of Medicine	\$ 79,909.67
Wright State University School of Medicine	\$ 23,103.10
TOTAL	\$262,272.38

AMA-ERF Special Research Grants

Donors may designate specific fields of research for their contributions. Included may be neuromuscular diseases, metabolic and endocrine diseases, neoplastic diseases, cardiovascular and pulmonary diseases, arthritis and rheumatism, and miscellaneous investigation.

Do You Need More Information?

If you have questions or need further information concerning the 1981 AMA-ERF campaign, do not hesitate to contact the Department of Health Education, OSMA, 600 South High Street, Columbus, Ohio 43215, (614)228-6971. **OSMA**

Robert D. Clinger is Director of the OSMA Department of Health Education and a Contributing Editor to the Ohio State Medical Journal.

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James Pohlman, Esq.

A Word of Advice

By James Pohlman, Esq. and Ralph Preston, Esq.

How do you report your returned stabilization reserve fund monies on your federal income tax return? The OSMA sought some legal advice on the matter.

Advice in this matter must be quite general, since the factual circumstances of one individual physician may differ substantially from those of any other. For example, those making the original payments (sometimes called the "premium increment" or "increments") into the Fund could have been individuals, partnerships, professional corporations, or government agencies; the Stabilization Reserve Fund may or may not have been deducted when paid; and so on. Nonetheless, a number of general comments and conclusions based on fundamental tax principles should be relevant to the situations of a large number of OSMA members.

One tax principle that appears to be applicable is the "tax benefit" rule, which generally requires that if a business expense deduction is taken in one year resulting in that year's federal income tax being lessened (the "tax benefit"), then if part or all of that expense is returned in a later year (eg, as here, in the form of a refund to the taxpayer), in a later year, so much of the returned amount which actually constituted a tax benefit in the earlier year is deemed to be income in the later year. Another applicable principle is that if a business expense is allocable to personal service income for purposes of the maximum tax on

personal service taxable income (Section 1348 of the Internal Revenue Code), that expense, when taken into income in a later year under the "tax benefit" rule, should be personal service income in the later year.

Applying these principles to the Stabilization Reserve Fund return, we believe the following tax consequences should result:

1. For the following persons **who paid their own SRF premium increment**: (a) a sole practitioner, (b) an employee of a partnership, professional corporation, or other organization, (c) a partner in a partnership, and (d) a shareholder in a professional corporation: If the SRF increment was deducted when paid (and assuming the individual had a net business income in that year), all amounts returned by the Stabilization Reserve Fund to that individual would be considered under the tax benefit rule as ordinary income when received. However, that amount of income should be subject to the maximum tax on personal service income (50%). If the SRF premium increment was not deducted as a business expense when paid, the individual should be able to receive up to the amount actually paid without realizing any taxable income. However, once the aggregate amount

Editor's Note: The Ohio State Medical Association (OSMA) has received a number of inquiries from members concerning how they should report, for federal income tax purposes, the Stabilization Reserve Fund monies which were returned to individual Ohio physicians by the Superintendent of Insurance in late August, 1980.

For this reason, the OSMA has asked James Pohlman and Ralph Preston, of the law firm Porter, Wright, Morris and Arthur, Columbus, Ohio, to offer its members advice on the subject. The following article has been prepared for your information.

paid to the SRF has been recovered, any additional return would be treated as ordinary income (and not subject to the maximum tax).

2. For an employee of an entity such as a partnership (excluding a partner), a professional corporation (excluding a shareholder), a hospital, a government agency, a medical school, etc., whose SRF premium increment was paid by his employer: If the monies returned by the SRF to the employee are returned to the employer who paid the SRF premium increment, there will be no tax consequences to the employee regardless of whether the amount paid was deducted by the employer. If, however, the SRF return is retained by the employee, it will constitute additional salary paid by the employer in the year received from the SRF. Characterized in that fashion, all amounts returned by the SRF should constitute ordinary income but will be subject to the maximum tax on personal service income. If the premium increment paid by the employer were treated as income to the employee in the year actually paid, then the employee who retains the

SRF refund would not receive any income until he had accumulated from the SRF an amount equal to that taken into income in prior years.

3. For a partner whose SRF premium increment was paid by the partnership and deducted as a business expense: If the SRF refund is returned to the payor partnership, there will be no tax consequences to the partner. However, the income item would appear in partnership income in the year returned. If the SRF refund is not returned to the partnership, the amount refunded would be viewed as a distribution by the partnership and characterized as ordinary income as to all amounts received from the SRF, but would be subject to the maximum tax on earned income.

4. For a shareholder of a professional corporation: If the shareholder-recipient returns the SRF refund to the corporation-payor, there will be no tax consequences to the shareholder, regardless of whether the professional corporation deducted the SRF increment. However, if the SRF return is retained by the shareholder, it will probably be characterized as a

dividend to the shareholder, which would be ordinary income not subject to the maximum tax on personal service income.

5. For the employer-payor (corporation, partnership, etc.) who paid and deducted the SRF premium increment: If the employee on whose behalf the SRF premium increment is paid retains the SRF return, there should be no tax consequences to the employer-payor. If, however, the SRF refund is returned by the employee to the employer-payor, the employer-payor would realize income to the extent of the return pursuant to the tax benefit rule.

The foregoing discussion and conclusions are intended to apply when the SRF premium increment was treated in all years in the same manner and should not be applied when the SRF premium increment was treated differently from year to year or when the increment was paid in more than one capacity in different years. Members should consult with their individual tax advisors concerning how the SRF refund should be treated in those specific situations. **OSMA**

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Ohio State Medical Journal Special Section

THE ^{STATE} Ohio ^{STATE} Medical Journal

Vol. 76 No. 11 November 1980



Special Section:

Third Party Carriers: Getting Through the Maze.

- Encounters of the Third Kind: An Overview.
- Medicare: How Fee Profiles Are Developed.
- A Complete Medicare Claim Form.
- Appeals, Medical Directors and Peer Review.

Introduction

This special section of the Journal launches a new monthly series of articles on third-party payers. They are written to provide physicians with some understanding of the third-party procedure, and how they can best work with the various systems. Future articles will take detailed looks at Medicaid, Blue Shield/Blue Cross, Bureau of Workers' Compensation, and private insurance companies. This month, a series of articles deals with Medicare, Part B, as administered by Nationwide Insurance Companies.

The Journal wishes to express its appreciation to Paul S. Metzger, M.D., vice president and chief medical director of the health and medical departments of Nationwide Insurance Company, for his help in assembling the articles featured in this section.

Members having specific questions or problems regarding third-party payers should contact Mr. Herbert E. Gillen, Director, OSMA Department of Government Relations.

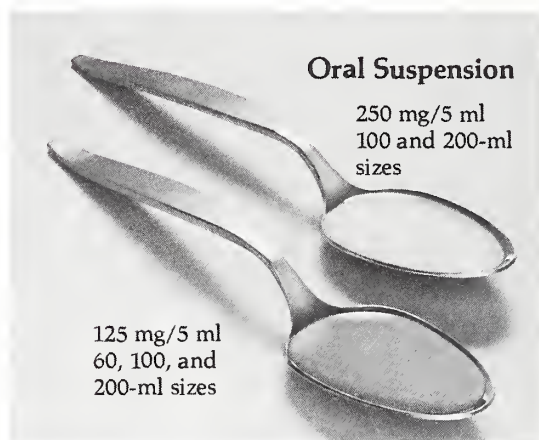
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Paul S. Metzger, M.D.

OSMA officers and Council have become increasingly aware that Ohio physicians frequently encounter problems related to third-party procedures. In response to these problems, this series of articles is presented in order to assist the physician in understanding third-party procedures — an understanding that will enhance efficient and effective billing practices, that will lessen the physician's paperwork burden, and improve the quality of the entire third-party function.

Third parties in the context of these articles are identified in Ohio as Medicare, Medicaid, Blue Shield/Blue Cross, Bureau of Workers' Compensation, and private commercial insurance companies. Medicare is administered under Part B in Ohio by Nationwide Insurance Company. Medicaid is administered by the Ohio Department of Welfare. Private insurance is offered and adjudicated by a large number of the commercial insurers and by the Blue Shield/Blue Cross organizations.

Improved understanding of the functioning of "third parties" is becoming necessary for physicians as

health care resources become more restricted. "Third parties" — whether public or private — are increasingly under pressure to limit continued expansion of available monies for health care purposes. This is occurring as the American public perceives tax dollars and premiums rising in lieu of increased wages and lessened taxes. Legislators and insurers are reacting to these public pressures by attempting to limit health care expenditures.

It follows that physicians must understand the entire process more thoroughly in order to permit them to compete appropriately for their fair share. Physicians may, at times, find themselves in competition with hospitals and with nonphysician providers for the limited health care resource. A thorough understanding of all the forces at work will enable the physician to render improved care to his patients and also to be compensated fairly for that care.

Initially this series deals with Medicare Part B as administered by Nationwide Insurance Companies. Subsequent articles will examine Medicaid, Blue Shield/Blue Cross, Workers' Compensation, and commercial insurance procedures.

It is important to define the particular "third party" that one is examining, as each has its own peculiar rules, regulations, and language. To date, many applied procedures are not interchangeable as illustrated by the various coding

systems currently utilized. Medicare Part B utilizes a modified four-digit coding system adopted from the 1964 California Relative Value System or CPT I; Blue Shield utilizes a five-digit system, and Medicaid uses CPT IV. Similarly, Blue Shield and commercial insurance define usual, customary, and reasonable (UCR) differently than Medicare which uses the terms customary and prevailing.

There are definite steps being taken to correct some of these deficiencies. For several years the AMA and certain Medicare carriers have been urging the Health Care Financing Administration (HCFA) to adopt a uniform coding system (CPT IV) and a universal claim form. HCFA has agreed that in 1981 such a system will be installed. The specific date has not been set, but hopefully such a step will enable physicians to devise a single uniform procedure in their office that will be acceptable to any and all third parties. This should enable streamlining of an office or billing system and lessen the paperwork burden and, at the same time, enable the carriers to more rapidly process claims.

These articles are intended to examine a number of aspects of the claims process, the routine claim process, including procedures utilized in complex claims, appeal techniques, mechanisms of establishing fee profiles, and the role of medical directors, organized medicine, and peer review. **OSMA**

Encounters of the third kind: an overview

By Paul S. Metzger, M.D.

^{must} What you ~~should~~ know about the Ohio Drug Substitution law

The state legislature has dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until now, writing the brand name of a drug on the prescription was enough to ensure that the brand-name drug would

indeed be dispensed. Now that no longer suffices. Unless the physician takes the necessary extra steps, for many drugs the pharmacist may substitute an "equivalent" generic drug.

Key points for the physician in writing prescriptions

- A pharmacist who receives a prescription for a brand-name dangerous drug may dispense any generically equivalent drug of the brand-name dangerous drug prescribed if the drug to be dispensed has a lower, regular, and customarily retail price than the brand-name dangerous drug prescribed and if the practitioner has not written in his own handwriting "Dispense As Written" or "D.A.W." on the prescription, or when an oral prescription is given, has not expressly indicated that the prescription is to be dispensed as communicated.
- No physician, dentist, veterinarian, or person licensed to prescribe any drug shall be liable for civil damages or in any criminal prosecution arising from the incorrect substitution by a pharmacist of another drug for the prescribed brand-name drug.
- The failure of a physician, dentist, veterinarian, or other person licensed to prescribe a drug to write "Dispense As Written" or "D.A.W." on the prescription shall not constitute evidence of the prescriber's negligence unless the

prescriber had reasonable cause to believe that the health condition of the patient for whom the drug was intended warranted the prescription of a specific brand-name drug and no other. No licensed prescriber shall be liable for civil damages or in any criminal prosecution arising from the interchange of a generically equivalent drug for a prescribed brand-name dangerous drug by a pharmacist, unless the prescribed brand-name dangerous drug would have reasonably caused the same loss, damage, injury, or death.

Rx

D.A.W.

Signature

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription language illustrated on the preceding page. This requires a distinct change from the way prescriptions were previously written.

The prescription may be filled generically unless the physician writes in his own handwriting "D.A.W." or "Dispense As Written." Only by adding this language can the physician ensure that the brand-name drug will be dispensed.

If the physician elects to permit substitution, no special indication need be made, since unless explicitly prohibited the pharmacist may substitute.

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There is no substitute for research.

Medicare: How fee profiles are developed

Physicians often request from carriers the methodology used concerning their fee profile development. Carriers for Medicare are required by regulation to follow rather precise techniques in developing fee profiles. To understand the process, it is first necessary to clarify the terminology.

Organized medicine has long used the terms "usual," "customary," and "reasonable" (UCR). However, Medicare, in developing its definitions, applied a different definition to customary. For Medicare, customary is defined as the individual physician's charge. It does not apply to any other physician. Prevailing, on the other hand, is the composite profile of all physicians of the same specialty in a designated geographic area.

The terms "reasonable charge" or "Medicare maximums" often are used by physicians and patients in discussing Medicare benefits. These terms frequently are misunderstood or confused with similar terms used by private health insurers. Although the calculations used to determine benefits are complex, there are a few basic guidelines which can help you and your patients interpret payments and gain a better understanding of the Medicare program.

Medicare benefits are based upon the lowest of three charges — actual, customary, or prevailing. After charges are determined to be covered expenses, and the patient's annual \$60 deductible has been satisfied, 80 percent of the lowest of these three charges is paid.

The **actual** charge is the charge

which appears on the claim for a given service.

The **customary** charge is based on a history of the physician's most common charge for a service. This data is collected from claims processed during the previous calendar year and, although these charges are updated annually, a customary charge could be based on data which is up to 18 months old.

charge data rather than judgmental determinations of reasonableness.

It is important to note that the federal government — not the insurance carrier — determines the methods to be used in calculating allowances. As a Medicare carrier, Nationwide is responsible for the administration of the program in strict compliance with policies and directives issued by the Health Care Financing

"It is important to note that the federal government — not the insurance carrier — determines the methods to be used in calculating allowances."

The **prevailing** charge is based upon comparisons made of the customary charges for all physicians of the same specialty in a particular geographic area. For example, an initial office call by a general practitioner is compared against customary charges for an initial office call by all general practitioners in the **same** locality.

Beyond these comparisons, computations are made which involve the government's economic index factor and other "gap filling" techniques when sufficient data is not available to compute customary or prevailing rates. Medicare "reasonable charges" are, for the most part, mathematically derived from historical

Administration.

Under existing regulations, Medicare carriers are responsible for developing customary charge profiles for individual physicians and prevailing charge profiles for physicians in the area. This guide is designed to explain the techniques prescribed by the Medicare program because of the varying interpretations being applied by other third parties, and by physicians, to the terms "usual," "customary," "reasonable," etc. The profiles are developed by physician specialty.

For Medicare purposes, carriers develop reasonable charge screens based upon the data derived from

claims processed during the base year selected by the Social Security Administration. For fiscal year 1981, a physician's customary charge screen is based upon data for claims processed during calendar year 1979. Medicare's fiscal year for profile development is for the period July 1, 1980, through June 30, 1981.

The maximum allowable charge for Medicare purposes for a given service is the lower of the customary charge or the prevailing charge (or the actual charge), from base year data as described below.

A. Customary Charge (For Each Individual Physician)

In calculating the customary charge limit for given service, each charge the physician has made for the service should be arrayed in ascending order. The lowest actual charge which is high enough to include the **median** of the array is then selected as the customary charge limit.

Procedure: Initial Office Visit

Step 1

Establish a frequency distribution listing each **actual** charge made by the physician in ascending order together with the frequency the charge was made:

(See **Fee Profiles 4**)

Step 2

To determine the customary charge,

select the lowest actual charge which is high enough to include the median of the array of charge data. In this example, the median of 391 is 196. This physician's customary charge for an initial office visit is therefore \$8.

B. Prevailing Charge (For All Physicians)

Public Law 92-603 (the 1972 Social Security Amendments) provided that prevailing charge levels used in determining Medicare reasonable charges for physicians' services would be limited by economic index data reflecting, on a cumulative basis, the increased costs of physician practice expenses and increases in general earning levels since calendar year 1971. The economic index applicable to prevailing charges for fiscal year 1981 has been determined by the Secretary of HHS to be 1.658 (ie, 65.8 percent above the fiscal year 1973 levels). This economic index for the 12 months beginning July 1, 1980, represents an 8.15 percent increase over the economic index (1.533) used for the previous 12 months.

Step 1

Establish a frequency distribution listing each customary charge (determined as above) in ascending order, together with the corresponding

frequency of the services rendered. (See **Fee Profiles 5**)

Step 2

To determine the prevailing charge, select the lowest customary charge which is high enough to include the customary charges of the physicians who rendered 75% of the cumulative services (the 75th percentile). In this example, 75% of the total of 5,000 services equals 3,750 services. The 3,750th service was rendered by a physician with a \$9 customary charge, therefore the prevailing charge for the service is \$9.

Step 3

The FY 1981 prevailing charge is determined by applying the prescribed index of 165.8% to the prevailing charge for FY 1973. That adjusted 1973 prevailing or the 1981 prevailing as determined in the above example, whichever is lower, is the prevailing charge for FY 1981.

It is important to note that these calculations must be made in the sequence shown above, ie, customary charges are developed for each physician and prevailing charges are developed from the data thus derived. The calculations are made from charges reported on Medicare claims only. **OSMA**

Fee Profiles — 4

Actual Charge	Number of Times Charged	Cumulative
\$ 7	150	150
\$ 8	100	250*
\$ 9	95	345
\$10	46	391
Total	391	

Fee Profiles — 5

Customary Charge	Number of Services Rendered by Physicians with Customary Charges as Indicated	Cumulative
\$ 7	1,402	1,402
\$ 8	1,115	2,517
\$ 9	1,680	4,197*
\$10	803	5,000
Total	5,000	

A complete medicare claim (Or how to stop trouble **before** it starts)

Administrators, physicians, and systems people have long recognized that a major problem between physicians and "Third Parties" is the claim form. The physician submits a claim on behalf of his or her patient only to find that something happens to delay payment. Often the problem is that the claim form does not contain the required information or the information is not presented in a manner that lay examiners can properly interpret.

The standard Medicare claim form labeled the "1490" is similar to the standard physician claim form developed by the AMA. Each requires a diagnosis or problem to be identified, dates of service, places of service, and procedure(s) performed. Charges must be identified for each procedure listed, notation made as to whether an assignment is accepted or not, and a signature.

Physicians may attach an itemized statement from their office to a "1490" claim form, however, the itemized statement must contain the above information. The regulations developed for the Medicare law are clear in that physicians may choose whether or not to elect an assignment. However, if they choose not to elect an assignment, they have the obligation of providing their patients with an itemized statement which the patient may attach to a "1490" claim.

However, a properly completed 1490 Medicare claim form can be processed quicker and with less chance of error

than when an itemized statement is attached. This is the primary reason that the Health Care Financing Administration (HCFA) has agreed to adopt the universal claim form (AMA) currently scheduled for implementation some time in 1981.

Nationwide recently conducted an analysis of the most common problems which result in delays or errors in payment. Three problems were identified which account for delays or errors in 15 percent of all claims received by Nationwide.

Of that 15 percent, absent or incomplete diagnosis accounted for the greatest single source of error. This includes inability to relate the procedures billed to the diagnosis listed. A requirement of the Medicare law is that the procedure performed, to be reimbursable, must be reasonable and necessary for the diagnosis(es) given.

Inadequate description of the procedure or service rendered accounted for the next greatest source of error. Narrative descriptions are easiest for the carrier to process if they have some uniformity. Nationwide prefers to utilize descriptions as published in its Newsletter for Physicians or to use Current Procedural Terminology. Numerical coding of procedures can be utilized but it requires each physician, clinic, or billing service to use the current four-digit system now in place at Nationwide. This coding system can be obtained from Nationwide.

The AMA's Current Procedural Terminology (CPT) (Fourth Edition) is acceptable but requires a conversion by the carrier. This adds an additional procedure in the carrier's processing and increases the likelihood of error.

The third most common error is failure to identify the physician rendering the service. This occurs where a group of physicians bill and the statement lists all the names under the letterhead without specifying on the statement or the 1490 the name of the physician rendering the service.

Additional problems which result in delays or payment errors include omission of lesion sizes on skin biopsies, whether lesions biopsied are malignant or benign, identification of fracture location and type, specific dates of hospital visits, and explanatory data to document unusual or extenuating circumstances.

In addition to supporting adoptions of the universal claims form and CPT IV, Nationwide continues to experiment with "paperless" processing utilizing data generated in the physician's office through terminals that connect with the carrier's system. This generates a claim process without the need for the usual claim form. Additional information on this process is available from Nationwide.

The volume of claims continues to increase for all carriers and Nationwide is no exception. During the past year, Nationwide Insurance (serving Ohio and West Virginia)

continued on page 679



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Appeals, medical directors, and peer review

Physicians often have questions concerning the manner in which complicated or unusual claims are handled by a carrier and methods available to them and their patients for redress where either the physician and/or the patient disagree with the final decision.

Nationwide's procedure for handling unusual or complex claims consists of a "tiered" system in which the initial examiner, when confronted with a procedure or diagnosis that does not fit with the listing available, "kicks out" the claim. This then becomes an "exception" and is routed through another group of experienced examiners who have had many years of claims experience. In many instances they are experienced nurses. When the problem is of such complexity that this group is unable to appropriately code and reenter the claim the problem shifts to Nationwide's Medicare Medical Department. Although this is the ultimate group for resolution within the internal operation of the carrier, it is not uncommon for a highly complex issue to require additional expertise. In these situations, outside consultations are obtained. The Medical Directors involved in Nationwide's Medicare operations are experienced, highly knowledgeable physicians. Their backgrounds include extensive experience in family practice, anesthesiology, and internal medicine. Nationwide's Medical Directors make



the final decision in approximately three percent of all claims received.

Additionally the Medical Directors are responsible for modifying and upgrading the coding system as it applies to new procedures, modification of established procedures, determining utilization parameters, submitting medical testimony in certain fair hearing problems, identifying and validating the various medical specialties, and determining medical necessity in situations where the medical appropriateness is in question. The Medical Directors also are responsible for establishing and maintaining satisfactory relationships with appropriate professional organizations throughout the carrier's territory.

The Medical Directors utilize the local county medical society Peer Review mechanism in those adjudication procedures where Peer Review is applicable. The carrier's Medical Department has strongly supported Peer Review and continues to urge county medical societies to maintain and foster effective Peer Review.

Due to the excellent relationships which have been established between the Medical Department and the Ohio State Medical Association, many complex and difficult issues have been resolved before they have created unmanageable problems.

Occasionally, adjudication proceedings are unsatisfactory to the

physician, the patient, or both, and an appeal is sought. The Medicare process has very specific appeals mechanisms. The first stage is the "reconsideration" request, which must be done by letter. Upon receipt of a letter, a reexamination of the claim is made utilizing any additional information submitted by the patient or the physician. In most cases, resolution of the dispute takes place at this level. However, in those rare situations where disagreement remains, the physician or the patient may request a "Fair Hearing." Only in those claim situations where the physician has accepted assignment can

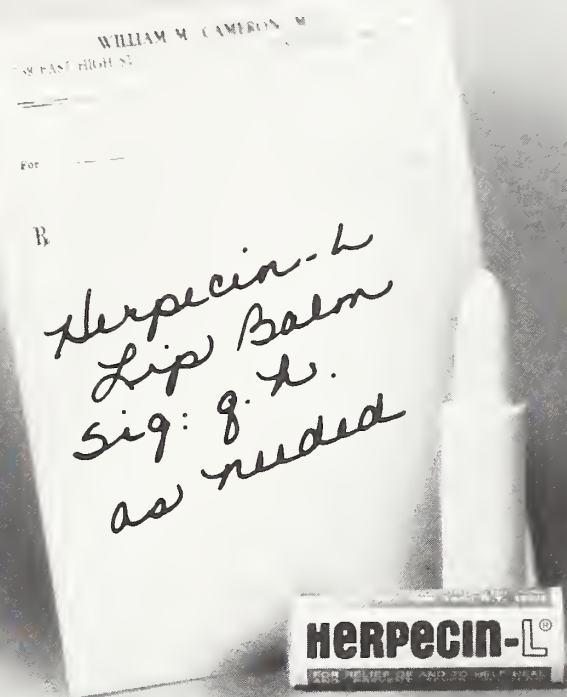
the physician request the Fair Hearing.

A Fair Hearing is scheduled by the hearing officer who has been appointed by HHS at which time testimony is given supporting the contentions of the patient or the physician (if involved). The Fair Hearing officer then considers the testimony and may in certain situations bring in expert medical witnesses or the carrier's Medical Directors for submission of testimony. The Fair Hearing officer weighs all the evidence submitted and renders a decision either upholding the carrier's original determination or modifying or reversing the original determination.

There is no legal appeal of the Fair Hearing officer's determination.

An additional note about Peer Review. Organized medicine has historically supported and participated in the Peer Review process. In spite of FTC activities that have thwarted certain aspects of Peer Review, it remains today as the most effective mechanism for resolution of misunderstandings between physicians, patients and third parties. Peer Review exemplifies that the private sector can devise a superior mechanism for resolution of problems and needs active physician support and involvement. **OSMA**

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A complete medicare claim (continued from page 676)

processed an average of 30,000 claims per day. More than \$1 million in benefits are disbursed daily.

Nearly 375 claims examiners are responsible for handling as many as 250 claims each per day. Claims which are complete and accurate are processed usually within 10 days. Claims which are incomplete can be

delayed as much as 55 days while additional information is obtained.

Filing Medicare claims should be no more complicated than dealing with commercial insurance carriers — the claims payment process is basically the same. One rule of thumb which always should be observed is this: Each claim must stand on its own.

Reference to previously processed claims is not made. Each individual claim is handled by using the information available on the claim as it is submitted.

Nationwide encourages physicians and their staffs to use the training resources available to them through the Medicare Field Service staff. **OSMA**

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When Impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

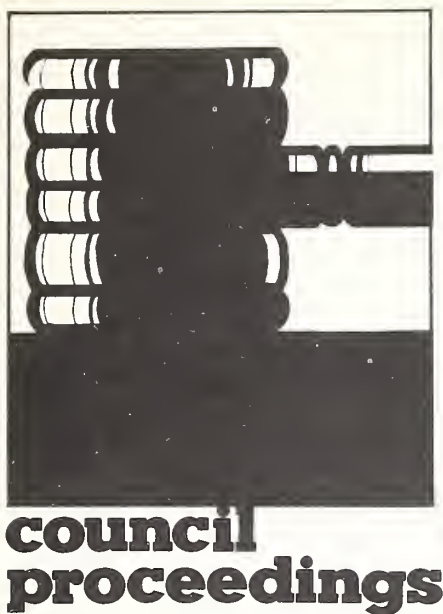


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PROCEEDINGS OF THE COUNCIL

September 13, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 13, 1980, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; John H. Ackerman, M.D., Columbus; Edward E. Grable, M.D., Canton; James E. Pohlman, Esq., Columbus; Dallas Gipson, Chief Executive Officer, Superior Computer Service; and Mr. S. H. Mountcastle, Akron.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson;

Richard A. Ayish; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; David W. Pennington; Erick Burkland; and Mike Bateson.

ADMINISTRATION DEPARTMENT

The minutes of the July 12, 1980 meeting of the Council *were approved*.

The minutes of the August 18, 1980 conference were ratified.

Stabilization Reserve Fund — In connection with the Stabilization Reserve Fund refund, the President commended Messrs. Mulgrew, Ayish and Burkland, of the legislative staff; Jerry Campbell; Mr. Pohlman and his colleagues; and the physicians on the SRF Board: Drs. Morgan, Thomas, Payne, Nowak and Henry.

The Council voted to thank Director Robin Ratchford of the Ohio Department of Insurance for his work on the SRF return and authorized a letter to this effect.

The Council voted to request that OSMA issue information to its members on the tax aspects of the returned money.

A motion to authorize the President to begin organizing the governing structure of the Ohio State Medical Association Education and Research Foundation was passed.

Pharmacopeial Convention — A motion to submit a candidate for the U.S. Pharmacopeial Convention, Inc., was passed and the Council authorized the President to select a member for this assignment.

Executive Director's Report — Mr. Page presented the Executive Director's report.

He announced an ad hoc Staff Task Force to monitor OSMA Long-Range Planning implementation as follows: D. Brent Mulgrew, Chmn.; Jerry J. Campbell; Rebecca J. Doll; Herbert E. Gillen; Robert E. Holcomb; and David W. Pennington.

Ad Hoc Task Force to Study the Leadership Conference, Interim Sessions and District Conferences — Dr. Dunsker reported on the September 12, 1980 meeting of the Ad Hoc Task Force to Study Leadership

Conference, Interim Sessions and District Conferences.

The minutes were re-referred to the Task Force for additional consideration.

OSMA House of Delegates Substitute Resolution No. 3-78 was referred to the Task Force.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Mrs. Wisse presented membership statistics.

Committee on Membership — Dr. Morgan presented the minutes of a meeting of the Committee on Membership held August 2, 1980.

The Council *approved* the Committee recommendations as follows:

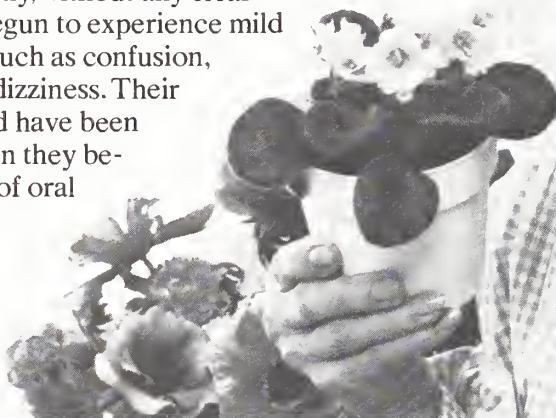
1. That medical students should be recruited for OSMA membership and that county medical societies should be involved in this activity.
2. That recruitment of residents (members in training) also be pursued.
3. That a renewed effort be made to enlist the interest and support of medical school deans and faculties in organized medicine.
4. That the general approach to recruitment of nonmembers be as follows:
 - (a) Personal contact of nonmember by *physician* member. Each physician recruiter would ideally contact no more than five nonmembers.
 - (b) Each recruiter would be identified, contacted, given instructions, provided with background material and provided with necessary application forms.
 - (c) The recruiters would report to county society president or some other responsible individual in the medical society. Reports could then be made to the Councilors or to this membership committee.

It was felt that prospective members

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

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How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg, packages of 100 and 1000.

Before prescribing, see package insert for full product information.

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should receive the OSMA membership kit from the recruiter.

The minutes of the September 12, 1980 meeting of the Committee on Membership were reviewed by Dr. Morgan.

The Council *approved* the Committee's recommendation to request funding from the Educational Commission for Foreign Medical Graduates for a special program or programs involving Ohio physicians.

A proposal for a dues refund program was discussed by Mr. Campbell. The Committee was authorized to investigate.

The report of the Committee was filed.

Treasurer's Report — The Treasurer's report was presented by Mrs. Wisse and it was filed.

Committee on Auditing and Appropriations — Mrs. Wisse presented the minutes of the Committee on Auditing and Appropriations meeting held September 9, 1980.

Mr. Mountcastle was introduced for presentation of a proposed project involving "tape-to-tape" billing of claims to the State Welfare Department.

The Council *approved* the concept that OSMA study the development of a computerized direct entry system for tape-to-tape billing of claims and authorized the Auditing and Appropriations Committee to act as an exploratory body to investigate the idea.

The Council *approved* the sharing with county medical societies of mailing and postage costs on a 50/50 basis, for membership recruitment campaigns.

The task of selecting a consultant to assist in assessing the structure of the Association, as in accordance with the Council action of January 27, 1980, was referred to a special committee of: Stewart B. Dunsker, Chmn.; Herman I. Abromowitz; David A. Barr; Thomas W. Morgan; H. Judson Reamy; and Robert G. Thomas.

The report, as a whole, as amended, was filed.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Education — Mrs. Dodson presented the July 17, 1980 minutes of the Committee on Education. The minutes were filed.

Committee on Program — Mrs. Dodson reviewed the minutes of the September 6, 1980 meeting of the Committee on Program.

The Council referred back to the Committee on Program the question of continuing the Monday afternoon session.

The report was filed.

Committee on Emergency and Disaster Medical Care — The minutes of the September 9, 1980 meeting of the Committee on Emergency and Disaster Medical Care were filed.

Council requested a staff update on "categorization" and regionalization of hospitals.

Consent Calendar — Resolution No. 19-80 was referred to the Membership Committee of the OSMA.

Awards — Dr. Charles L. Hudson, of Bratenahl, was nominated for the 1981 Distinguished Service Award of the OSMA.

It was voted that Dr. Hiram Weiss, of Cincinnati, receive a special award.

DEPARTMENT OF GOVERNMENT MEDICAL CARE

Mr. Pennington presented an update on health planning.

The Council requested Mr. Pennington to draft recommendations concerning the establishment of an OSMA Committee to function in the health planning area.

Committee on Cost Effectiveness — Dr. Diller reported the minutes of the September 10, 1980 meeting of the Committee on Cost Effectiveness.

The Council appointed Dr. Abromowitz as cochairman of the Ohio Voluntary Effort.

The Council *approved* the recommendation that serologic testing for syphilis for routine hospital admission be discontinued and the law requiring premarital serologic testing for syphilis be repealed.

The report was filed.

Committee on Rehabilitation — The minutes of the September 10, 1980

meeting of the Committee on Rehabilitation were presented by Mr. Gillen.

The Council *approved* a recommendation of the Committee that articles on the new rehabilitation functions of the Industrial Commission be published in the *Ohio State Medical Journal*.

The Council also *approved* the suggestion that OSMA present names of physicians to serve on Medical Advisory Boards to be established under the program.

The report was filed.

DEPARTMENT OF ORGANIZATIONAL SERVICES

Physicians Insurance Company of Ohio — A report on Physicians Insurance Company of Ohio was presented by Drs. Thomas and Payne, indicating significant gains in the services of that company to physicians.

Dr. Thomas outlined his concern for the development of a long-range "business plan" for the company and solicited input from the Council to the members of the Board of Directors, whose obligation it is to develop and implement goals for the company.

American Medical Association — The Chairman of the AMA Delegation, Dr. Clarke, reported on recommendations for Drs. Jerry L. Hammon and Sylvan L. Weinberg, both of Dayton, for an AMA Council on Medical Education Task Force.

The Council *approved* the Delegation's recommendation.

Dr. Clarke also asked for approval of the Delegation's support of Dr. Robert N. Smith, Toledo, for the AMA Council on Legislation, and it *was approved*.

He announced that Dr. W. Jack Lewis again will run in June, 1981, for the AMA Board of Trustees and Dr. John Beljan for the Council on Scientific Affairs.

It was announced that Dr. John J. Gaughan, Cleveland, has been appointed to Reference Committee B and Dr. Clarke is again Chairman of Reference Committee F for the Interim Session in December 1980.

Dr. Clarke discussed the problem presented by the Graduate Medical Education National Advisory Committee.

Medical Services Review Committee — The minutes of the Medical Services Review Committee meeting of September 13, 1980, were presented by Dr. Dörner.

The report was filed.

DEPARTMENT OF HEALTH EDUCATION

Joint Advisory Committee on Sports Medicine Subcommittee on Playoff Coverage — Mr. Clinger presented the minutes of the July 24, 1980 meeting of the Joint Advisory Committee on Sports Medicine Subcommittee on Playoff Coverage. A recommendation that the use of student trainers and other noncertified trainers be authorized only under direction of a certified athletic trainer *was approved*.

The report was filed.

Joint Advisory Committee on Sports Medicine Subcommittee on Awards — Mr. Clinger presented a report of the July 24, 1980 program of the Joint Advisory Committee on Sports Medicine Subcommittee on Awards.

The report was filed.

Joint Advisory Committee on Sports Medicine Subcommittee on Education — The minutes of the Joint Advisory Committee on Sports Medicine Subcommittee on Education meeting held September 4, 1980 were presented by Mr. Clinger.

The Council *approved* recommendations as follows, with the request that the Council have the opportunity to review the second item:

1. That guidelines and methodology for CPR training and for a sports-related first aid training course for scholastic coaches *who are not certified teachers* be presented to the Ohio State Board of Education as directed by enactment of Amended House Bill 251 and Ohio State Board of Education Rule 3301-27-01.
2. That an advanced course be designed for coaches who have completed requirements for the voluntary "interscholastic coaching certificate," or have completed an approved college or university course on the health and safety of participants in the activity program, or who have completed the CPR and basic first aid training requirements — to become effective

on July 1, 1983 as directed by Rule 3301-27-01.

3. That OSMA serve as a cosponsor of the Seventh Postgraduate Institute on Sports Medicine to be held at The Ohio State University on August 18-20, 1981. In charge is OSU Director of Sports Medicine Robert J. Murphy, M.D. OSMA served as a cosponsor for the six previous Institutes.

The report was filed.

Impaired Physician Conference — Mr. Clinger reviewed the program for the Impaired Physicians Conference March 14-15, 1981, to be held in Worthington, Ohio.

The report was filed.

Committee on Health Manpower — The minutes of the August 28, 1980, meeting of the Committee on Health Manpower were presented by Mr. Clinger.

The Council voted to *approve* the Committee's recommendation in support of the Ohio State Medical Board position paper on June 10, 1980, entitled "Interpretation of Statutes regarding the Status of Nurse Practitioners, Nurse Clinicians, Clinical Nurse Specialists, and Individuals Identified by Other Similar Titles."

The Committee also redirected the Council's attention to the definition of the Nurse Practitioner in OSMA House of Delegates Resolution No. 49-78.

The report was filed.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

The district legislative materials were reviewed by Mr. Mulgrew who called attention to OSMA's newest publication "Physicians Guide to Ohio Law."

Mr. Mulgrew discussed current developments in Congress and the election campaigns.

State Legislation — Mr. Ayish discussed the return of the Stabilization Reserve Fund.

Mr. Ayish reviewed the Hospital Licensure bill and the Ohio State Medical Board bill, both currently being heard in the Ohio General Assembly.

Jail Project — Mr. Ayish announced that Ohio has now accredited 14 jails under the OSMA Jail Program.

He introduced Mr. Michael Bateson, who has joined the OSMA staff as Jail Project Director.

COMMUNICATIONS DEPARTMENT

Synergy — Ms. Mullinax reported on *Synergy* use by industrial firms for their employees, and the development of health columns for school newspapers.

Focus Group Interviews — Ms. Doll reported to the Council on the Focus Group Interviews conducted throughout the state by the Department of Communications.

Ms. Doll indicated that new public service announcements will be distributed to the electronic media this month.

The Council voted to increase the advertising rates of the Journal 10% for next year.

Auxiliary — Dr. Pfahl presented the minutes of a meeting of the Auxiliary Advisory Committee held September 13, 1980, concerning a proposed coloring book, containing health information. The Council *approved* their request to produce a coloring book contingent on the approval of the Auxiliary Board of Directors.

A loan of not to exceed four thousand dollars as "seed money" *was approved*.

Miscellaneous promotion services for the project by the OSMA Communications Department *were not approved*.

FIELD SERVICE DEPARTMENT

Mr. Holcomb distributed the revision of County Medical Society Model Bylaws.

National Health Service Corps — National Health Service Corps meetings for residents were discussed by Mr. Holcomb for the information of the Council.

COUNCILOR REPORTS

The Councilors reported on activities in their respective districts.

LEGAL COUNSEL REPORT

The Legal Counsel report was presented by Mr. Pohlman.

OHIO DIRECTOR OF HEALTH

Dr. John Ackerman, Ohio Director of Health, addressed the Council.

He said that the mosquito problem is acute, but no increase in encephalitis has been reported.

He reported that the Ohio Public Health Council has just adopted new rules for C.T. Scanners with hearings scheduled October 16, 1980.

Also to be heard by the Ohio Public Health Council are rules on genetic testing program called for in H.B. 1056 of the Ohio Legislature.

There being no further business the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

English pronunciation for foreign physicians offered by AMA

Next November, the American Medical Association will offer an intensive one-day course on improving English pronunciation for foreign physicians.

The course is designed to assist foreign physicians, now in practice in the United States, in improving spoken communications with their patients.

Sessions will be held Saturday, November 15, at the Grand Hyatt Hotel in New York City. Physicians attending will receive formal credits in continuing medical education.

The course will be taught by Mrs.

Elizabeth Land, professor of English as a second language, Cuyahoga Community College, Cleveland, Ohio.

There will be lectures and practice on producing the sounds of general American English, intensive oral drill, and practice in sustained discourse through reading and extemporaneous speaking.

Further information on the course is available from Henry Mason, Division of Professional Relations, AMA, 535 N. Dearborn St., Chicago, IL 60610. Course director is Mortimer Enright, head of the AMA's Speakers and Leadership Programs Section. **OSMA**

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Obituaries

JURGIS BALCIUNAS, M.D.,
Bolivar, Vytauta Didziojo University
Medical Fakelteto, Kaunas, Lithuania,
1933; age 74; died September 8;
member OSMa and AMA.

DANIEL BIRMINGHAM, M.D.,
Shadyside; John Hopkins University
School of Medicine, 1949; age 58; died
August 28; member OSMa and AMA.

CLEON C. COUCH, M.D., North
Canton; Case Western Reserve
University School of Medicine, 1936;
age 72; died August 20; member
OSMa and AMA.

ROBERT J. ENGLISH, M.D.,
Toledo; Northwestern University
Medical School, Chicago, 1936; age 71;
died August 24; member OSMa and
AMA.

DOROTHY FALKENSTEIN, M.D.,
Columbus; Ohio State University
College of Medicine, 1936; age 69; died
September 23; member OSMa and
AMA.

HENRY L. HARTMAN, M.D.,
Toledo; Yale University School of
Medicine, New Haven, Connecticut,
1935; age 70; died August 23; member
OSMa and AMA.

VISHWA N. KAPUR, M.D.,
Cleveland; Medical College, Calcutta
University West Bengal, India, 1949;
age 60; died September 5; member
OSMa.

HARRY J. KUMIN, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1927;
age 76; died August 22; member
OSMa and AMA.

RICHARD E. LEWIS, M.D., St.
Clairsville; Case Western Reserve
University School of Medicine, 1954;
age 54; died March, 1979; member
OSMa and AMA.

CONSTANTINE ROUSSE, M.D.,
Akron; State University of New York
at Buffalo, School of Medicine, Buffalo,
1962; age 47; died August 24; member
OSMa and AMA.

FRANK SCHERGER, M.D., La
Puente, California; age 67; died
September 4.

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in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

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LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
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2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be **TYPED DOUBLE OR TRIPLE SPACED** with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. The *Journal* will assume \$10 of this expense and the author will be billed by The *Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has written releases on all photographs in which patients can be identified.

5. **ABSTRACTS.** A short (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go about it. *Ohio State M J* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: *Modern Medicine*. ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at \$2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

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CONTINUING EDUCATION PROGRAMS



November

TRAUMA AND DISASTER SYMPOSIUM "THE MILITARY AND CIVILIAN EXPERIENCE": November 15-16; Columbus Hilton Inn, 3110 Olentangy River Road; sponsor: 2291st U.S. Army Reserve Hospital and 112th Medical Brigade; cosponsor: Ohio State University College of Medicine; 9 credit hours; fee: \$35; contact: Jon Hollett, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

GERIATRICS - KIDNEY FUNCTION, URINARY TRACT INFECTIONS, AND URINARY TRACT INCONTINENCE IN THE AGED: November 19; Holiday Inn, 328 West Lane Avenue, Columbus; sponsor: Ohio State University College of Medicine; 5 credit hours; fee: \$47, \$27 for nurses and others; contact: Jon Hollett, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

SIXTH ANNUAL CHILD PSYCHIATRY SYMPOSIUM - AGORAPHOBIA: November 21; Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine; 6 credit hours; fee: \$52; contact: Jon Hollett, Center for

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January

MANAGEMENT OF SURGICAL PROBLEMS: January 15-16; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$170, \$85 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

February

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: February 22-March 1, 1981; S.S. Norway Caribbean Cruise; sponsor: University of Cincinnati College of Medicine; 32 credit hours; fee: \$390; contact: Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati College of Medicine, Room 6507, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4155.



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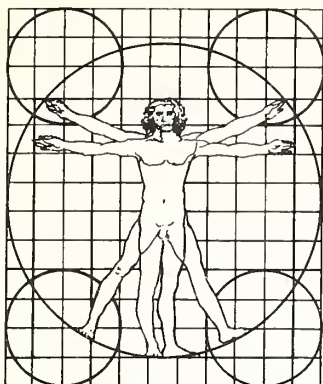
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CLINICAL & SCIENTIFIC

SLEEP SHOULDER SYNDROME

Charles T. Wehby, M.D.
John H. Wehby, M.D.

Sleep shoulder syndrome is an entity which human flesh has been heir to from time immemorial. Its covert etiology, anatomical basis, prevention, and therapeutics is embodied herein. The capability of deliberately resurrecting the symptom complex after successful therapy has a Kochian accent and proves the etiologic basis for the symptomatology. The essential lesion is a traumatic insult of the ventral component of the deltoid and shaft of the humerus, affected by their exposure to the pressure from the head when the arm is rotated medially and the short head of the biceps brachialis falls forward and downward. This point der Schwerpunkt (the crucial point) elicits exquisite pain when deeply palpated, and is pathognomonic for sleep shoulder syndrome.

SHOULDER COMPLAINTS flourish abundantly in an office environment. It is not our intention to present a warmed-over discussion of the usual modalities, but to introduce a new syndrome which is very common, has an occult cause, low morbidity profile, and dramatic response to appropriate therapy based on a scientific appraisal of etiology. This symptom complex is appropriately referred to as the sleep shoulder syndrome.

To date the low morbidity profile and occult etiology of the syndrome have collectively shielded its exposure from sophisticated medical appraisal. In short, the syndrome has its genesis and exodus in an office atmosphere. However, for the complainant, the realities are painful and frustrating, and are referred to usually in the course of managing a more acute complaint.

Symptoms, Signs, Incidence

It has been found that the complainant, on questioning, is invariably a young to middle-age individual who: (1) is undergoing a real or apparent emotional insult, or to paraphrase Shelley, one who has "fallen upon the thorns of life," and is experiencing attendant anxieties; (2) reveals frequent episodes of awakening with pain in the arm and changes position frequently; (3) sleeps on either side or abdomen with right or left arm extended and placed against the side of the head, with the pinna and the temporal area of the skull impinged against the anteromedial inferior aspect of the deltoid area of the forearm; (4) upon awakening, experiences pain with all movements of

the shoulder (especially anteromedial rotation), except external rotation which gradually disappears completely, only to recur the following day; and (5) on physical examination, displays point tenderness over the ventral belly of the deltoid and the shaft of the humerus.

Anatomical Considerations and Signs

The diagnosis of sleep shoulder syndrome can be readily made by applying anatomical expertise and the physical diagnostic principles of history, inspection, and palpation. Of these five, the history is the *prima-inter pares* since it will betray (1) the nature of the cause (anxiety and improper sleep posture); (2) transiency of the symptoms; and (3) site and nature of the insult.

The essential lesion is a traumatic insult to the ventral component of the deltoid and underlying shaft of the humerus. In sleep shoulder syndrome, a virtual tamponade of these modalities is effected by using the head as a hammer and the body of the humerus as an anvil. It has been noted that as the shoulder is rotated medially, the short head of the biceps brachialis retracts medially and dorsally and exposes the ventral belly of the deltoid to its narrowest point in relation to the body of the humerus. It is exactly at this point *der Schwerpunkt*, that exquisite tenderness is elicited on palpation.

Treatment

Since it has been shown that sleep disturbance, precipitated by anxiety and improper sleep posture, combine to cause the sleep shoulder syndrome, it follows that a rational approach to counteract these factors must be instituted if success is to be achieved.

The cardinal principle is to insist that the patient sleep either on the back or abdomen, with arms as far removed from the head as possible. If, as has been noted, the patient is unable to relax without placing the upper arm against the head, then a pillow must be inserted between the head and shoulder to minimize pressure.

The treatment of anxiety presents a difficult but not insurmountable problem. The principle of adjust, absent, or be destroyed must be made unmistakably clear to the patient. An attempt to riposte the winds of fate, so that euphony rather than cacophony dwells in their forested minds, must be diligently pursued.

Dr. Charles T. Wehby, Cincinnati, Family Practitioner and Staff Member, Good Samaritan Hospital.

Dr. John H. Wehby, Third-Year Resident in Internal Medicine, Marshall University School of Medicine.

Submitted November 21, 1979.

Usually, dramatic results are forthcoming with these approaches alone. However, tranquilizers and/or central muscle relaxants may be prescribed temporarily.

Comment

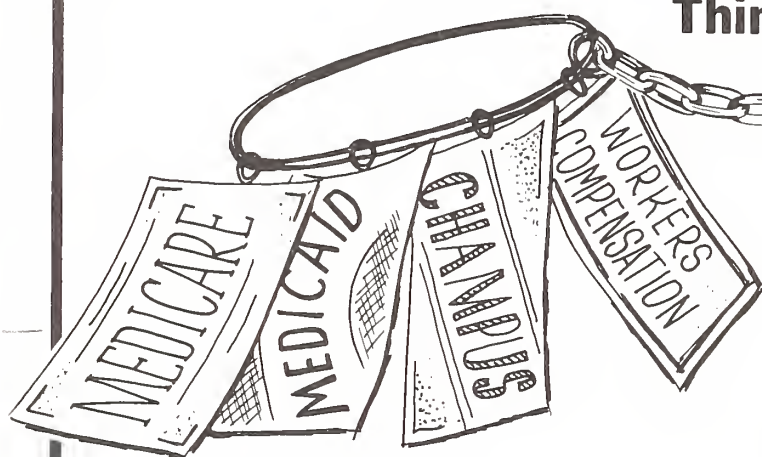
The authors have observed 65 patients with sleep shoulder syndrome who have obtained relief by following the treatment described herein. A total of ten patients were asked to disregard all remedial measures that had been successful in relieving their pain, and revert to their usual sleep habits. All ten experienced an immediate return of symptoms which, in our opinion, coincides with Koch's premise for cause and effect, or *post hoc ergo propter hoc*.

Insofar as we have been able to ascertain, the fact that sleep shoulder syndrome is an entity heretofore unearthed is un-

challengeable. The covert nature of its genesis and the relatively low morbidity profile undoubtedly explain the unconscionable delay in researching and solving this disability. Nevertheless, the gratification and appreciation of the sufferer of this syndrome is adequate compensation to the attending physician who presumes to quote the Miltonian observation that "They also serve who only stand and wait," and also see and report.

Acknowledgments: The authors appreciate the assistance of Mrs. Ethel M. Wehby, Charles T. Wehby, Jr., Carol Wehby Glenn, and Donna Wehby LaVilla, in the preparation of this article.

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Another Service of Your OSMA

Arthritis care and education program offers help

The Arthritis Care and Education Program, now entering its fourth year of funding by the Ohio Department of Health, is helping to train the professional community in the care and treatment of arthritis, reports the Publications Section of the Ohio Rheumatism Society. The programs offered include: one-year postdoctoral

fellowships, four-week fellowships for primary care physicians, family practice and internal medicine residents, two-week training programs for allied health professionals, and one-day outreach programs for health care providers in a variety of settings, such as hospitals, medical societies, health agencies, and other medical

institutions. In addition, the program also supports a number of research training awards. These programs are offered through the Arthritis Foundation Chapters, in cooperation with the major medical training centers of Cincinnati, Cleveland, Columbus, and Toledo.



STATE

NEW LEADERSHIP

Reflecting the similar political circumstances of the federal government, Ohio state government of 1981 and 1982 will be overseen by a Republican executive leader, a Republican Senate, and a Democratic House. This political structure in Ohio comes with the significant electoral successes of the Republican Party: regaining a lost majority in the Senate and new electoral respect in the House. For the first time in years, Republican House members entertain a realistic hope of obtaining majority status, while fellow G.O.P. legislators prepare to take control of Senate committees.

Meanwhile, the Democratic Party, many of its leaders encountering electoral unemployment or the underemployment of minority position, faces an introspective reorganization with consideration for change in leadership, campaign methods, and policy. Despite witnessing years of increasingly well-organized, well-financed Republican campaign efforts, widespread defeat at the polls came as a shock to many Democratic officials. In the immediate aftermath of the General Election results, Democratic policy initiatives probably will be more tentative and less successful.

Legislative leadership changes followed the election quickly. Within the Ohio Senate Republican caucus, Paul E. Gilmor of Port Clinton, Thomas A. VanMeter of Ashland, and Stanley J. Aronoff of Cincinnati, retained their leadership positions. When the 114th Ohio General Assembly convenes next month, Gilmor becomes President of the Senate, VanMeter becomes President Pro Tempore, and Aronoff assumes the title of Assistant President Pro Tempore. VanMeter, who often is credited with orchestrating the Republican campaign effort, has indicated an interest in running for statewide office in 1982.

The 1981-1982 leadership team of the Senate Democrats is somewhat less clear. In a caucus meeting one week after the election, eight Democratic senators voted to replace Oliver Ocasek of Northfield as caucus leader; the other seven Democratic senators of the upcoming General Assembly boycotted the meeting. Those eight senators attending the meeting elected Harry Meshel of Youngstown as their leader; Neal F. Zimmers, Jr. of Dayton as Assistant Minority Leader; Charles L. Butts of Cleveland as Minority Whip, and Timothy McCormack of Euclid as Minority Floor Leader, a new post with no extra pay. Ocasek stated that he was not prepared to accept the vote. Nevertheless, at the time of this writing, the results of the vote have not changed.

The Democrats retain control of the Ohio House, although the loss of six members reduces to 56 the number of seats they occupy in the 99-member chamber. The House Democratic caucus retains Vern Riffe of New Boston as Speaker; Barney Quilter of Toledo as Speaker Pro Tem-

pore; William L. Mallory of Cincinnati as Majority Floor Leader; and Vernon F. Cook of Cuyahoga Falls as Assistant Majority Floor Leader. However, by one vote, Francine M. Panehal of Cleveland was unseated as Majority Whip by Arthur Wilkowski of Toledo. Wilkowski apparently won the post without the support of the Speaker.

The House Republican caucus exhibited somewhat deeper divisions in its leadership elections. The caucus dispatched a displeased William G. Batchelder of Medina and Donna Pope of Parma from their posts as Assistant Minority Leader and Minority Whip. Elected to the posts were Ben Rose of Lima and Helen H. Fix of Cincinnati. Batchelder publicly accused Michael Fox of Hamilton, coordinator of the first successful House Republican campaign effort in eight years, of using Republican campaign funds to build support for Rose and Fix. Fox publicly replied that Batchelder and Pope had defeated themselves earlier this year with an abortive "dump Nixon" attempt.

NEW FACES

The following are the new state senators, each of whom defeated incumbent legislators:

(1) **Senator Michael DeWine**, a Republican from Greene County. DeWine was the county prosecutor and takes the 10th District seat held by John Mahoney.

(2) **Senator Steven Maurer** of Botkins, the sole new Democratic senator. Botkins previously served as village clerk-treasurer. He unseated Richard Ditto in the 12th District.

(3) **Senator Ben Skall**, a Lyndhurst businessman and a Republican. Skall defeated 22nd District Senator Anthony Calabrese.

(4) **Senator Gary Suhadolnik**, a Republican who was elected to the 24th District seat occupied by Jerome Stano. Suhadolnik is an engineer.

(5) **Senator Bill Ress**, who defeated Kinsey Milesen in the 30th District. Two years ago, Ress, a Republican, was unsuccessful in a race with Douglas Applegate for the Congressional seat formerly held by Wayne Hays.

Below is a list of the first-term representatives of the 114th Ohio General Assembly:

(1) **Representative James Petro**, who took the seat vacated by James Betts, unsuccessful candidate for U.S. Senate. Petro is a Republican attorney from Rocky River.

(2) **Representative Lee Fisher**, a Democratic attorney from Shaker Heights. Fisher replaces Democrat Harry Lehman, the Judiciary Committee chairman who retired to the practice of law.

(3) **Representative Jo Ann Davidson**, a Republican and former director of legislative services for the Ohio Chamber

of Commerce from Reynoldsburg. Davidson occupies the seat vacated by Republican Alan Norris, who was elected to the 10th District Court of Appeals.

(4) **Representative Larry Ballweg**, a Montgomery County hardware store owner. Ballweg, a Republican, won election to the seat vacated by Democrat Paul Leonard, an attorney.

(5) **Representative Peg Bowman**, a former mayor of Elyria. Bowman defeated a first-term incumbent Democrat, John Bara.

(6) **Representative John O'Brien**, a Republican who won election to the seat vacated by Robert Taft, the new Hamilton County commissioner. O'Brien is director of records and research for the University of Cincinnati Foundation.

(7) **Representative Russ Guerra**, who defeated incumbent Democrat Larry Christman. Guerra is a former police officer.

(8) **Representative Ronald Amstutz**, former mayor of Orrville. Amstutz, a Republican, holds the seat vacated by John Johnson, a Democratic attorney.

(9) **Representative Joseph Haines**, a Xenia farmer who replaces Robert McEwen, who won election to Congress. Both are Republicans.

(10) **Representative Steven Williams**, an attorney from Lancaster. Williams, a Republican, defeated incumbent Democrat Don Maddux.

(11) **Representative Robert Ney**, a Bellaire Republican. Ney defeated Wayne Hays.

NEW LAWS

Below is a list of bills of interest to medicine that were enacted by the 113th General Assembly:

Stabilization Reserve Fund Return: Senate Bill 271, effective December, 1979, mandated the return of approximately \$26 million from the Stabilization Reserve Fund to Ohio physicians and hospitals.

Medical Records: House Bill 80 requires employers to provide a copy of any employee's medical record at his or her request. Senate Bill 62 excludes medical records from those public records that are open for public inspection.

Controlled Substance Research: Senate Bill 184 created a program to research the medical uses of marijuana.

E.M.S. Immunity: House Bill 201 expands immunity given to emergency medical personnel to individuals involved in receiving or dispatching requests.

E.M.S. for Miners: House Bill 419 requires operators of underground mines and quarries to provide emergency medical services and training for mine employees.

Cornea Transplants: House Bill 415 permits the removal of donor eyes for corneal transplants and other medical or research purposes from bodies which a county coroner autopsies.

Comparative Negligence: Senate Bill 165 substitutes a form of comparative negligence for the common law doctrine of contributory negligence in the determination of the right of recovery and the amount of damages in negligence actions.

Newborn Testing: House Bill 1056 requires testing of newborns for homocystinuria, galactosemia, and hypothyroidism.

C.P.R. Training: House Bill 481 requires that a cardiopulmonary resuscitation course be offered in all high schools.

FEDERAL

A LOSS OF SENIORITY

Both the Republican and Democratic congressional delegations of Ohio are reduced in seniority, as four well-tenured Congressmen will not return to Washington for the 97th Congress. Republican Congressman William Harsha of Batavia and Democratic Congressman Charles Vanik of Lyndhurst retired this year after long service in the U. S. House. Incumbent Republican Sam Devine of Columbus and incumbent Democrat Ludlow Ashley of Toledo were upset by challengers on November 4th.

Devine was defeated by Columbus attorney Robert Shamansky by more than 10,000 votes. The third-ranking Republican member of the House, Devine served in Congress for 22 years in what has traditionally been considered a Republican district in Franklin County.

In heavily Democratic Lucas County, Ashley lost to the well-structured campaign effort of Republican Ed Weber by a wide margin. Ashley was a member of Congress for 26 years.

The Republicans held the 6th District of south-central Ohio, which was vacated by Congressman William Harsha. The seat now is occupied by Robert McEwen of Hillsboro.

In Cuyahoga County, Democrat Dennis Eckart of Euclid now represents the 22nd District. That seat had long been held by Charles Vanik, who retired.

The exchange of the Franklin County and Lucas County seats, the party replacements in Cuyahoga County and south-central Ohio, and the return of all other incumbents leaves the political makeup of Ohio's delegation to the 97th Congress unchanged. For the next two years, Ohio will be represented in Washington by 13 Republicans and 10 Democrats. By 1982, Ohio will probably lose two of its current 23 congressional seats through reapportionment, as a result of the relative loss of population in the state during the past decade. Just which seats will be eliminated will be determined by a reapportionment plan that must be approved by both houses of the state legislature. Because of this approval procedure, the Senate Republican victory in Ohio assumes importance to future Republican congressional campaigns.

The newcomers to the 97th Congress from Ohio are:

(1) **Congressman Dennis Eckart**, 30, formerly state representative and an attorney.

(2) **Congressman Bob McEwen**, 30, formerly a state representative.

(3) **Congressman Bob Shamansky**, 53, an attorney and a television talk show host.

(4) **Congressman Ed Weber**, 49, a Toledo attorney.

Features

Ohio's Communicable Diseases Why aren't they being reported? 707

Karen S. Edwards

When communicable disease reporting figures dropped so low as to be almost unbelievable, the Ohio State Medical Association, in cooperation with the Ohio Department of Health, decided to find out why.

ABC, NBC, or CME? 713

Carol W. Mullinax and Karen S. Edwards

Don't touch that dial! For some Columbus physicians, the miracle of "Qube" TV is bringing CME courses right into the comfort of their own living rooms.

Two Wheels on the Road 721

Karen S. Edwards

Bicycles aren't "just for kids." A Cincinnati-area physician wouldn't trade his "two wheels" for any four-wheel drive on the road.

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Our Cover

"Colorado Moonshine" is the name of this "Outstanding Entry" in the *Ohio State Medical Journal's* Photographic Exhibit Contest. Lewis Coppel, M.D., from Chillicothe caught the moon glorifying a Colorado ski run with an Olympus camera, equipped with a 2.8 mm lens. Shot at F.2 at 1/250, Dr. Coppel used Kodachrome 64 film.



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Ohio's Communicable Diseases:
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Two Wheels on the Road
Bicycling is not just for kids

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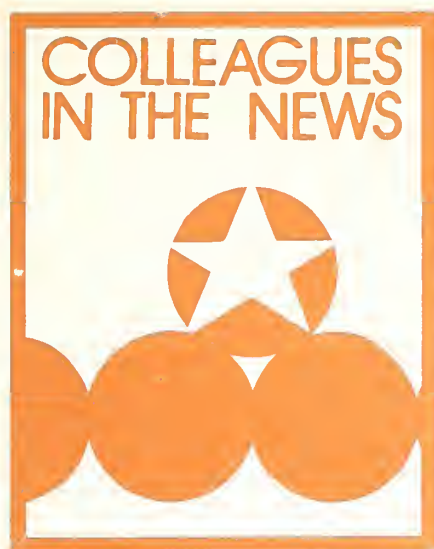
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ROMEO T. BACHAND, JR., M.D., Painesville, was appointed president and general manager of Les Laboratoires Servier, a pharmaceutical company with headquarters in Paris, France. Dr. Bachand's job will be to build up American operations of the 22-year-old company which will employ 300 to 400 people.

JOHN R. BROWN, M.D., Dayton, was elected president of the American Cancer Society, Ohio Division, Inc. Other officers include: William T. Collins, M.D., Lima, vice president, and Paul R. Zeit, M.D., Burton, secretary.

CRAIG G. BURKHART, M.D., Toledo, was appointed to the editorial board of the Journal of Current Adolescent Medicine. Dr. Burkhardt is head of dermatology at the Medical College of Ohio and editor-in-chief of the Journal of Dermatology and Allergy for the Practicing Physician.

JAMES W. COTTRELL, M.D., Steubenville, was named director of anesthesiology at the Ohio Valley Hospital. Dr. Cottrell has served as assistant director of anesthesiology since July 1978.

DONALD C. FISCHER, M.D., Cincinnati, was elected vice president and president-elect of the American College of Physician Executives, a division of the American Academy of Medical Directors. Dr. Fischer is vice president-medical director of Good Samaritan Hospital.

WILLIAM E. FORSYTHE, M.D., Cleveland, was named president-elect of the North Central section of the American Urological Society. Dr. Forsythe is chief of urology at Glenville Hospital.

VERNON D. HACKER, M.D., Euclid, was named president-elect of the Cleveland Surgical Society.

ARTHUR J. HORESH, M.D., Cleveland, was appointed regional coordinator for Northern Ohio in a new public education campaign called National Crusade Against Asthma and Other Allergic Diseases. Dr. Horesh is a member of the executive board of the Asthma Care Association of America.

RAYMOND S. LUPSE, M.D., Youngstown, was appointed chairman of the Special Projects Committee of the American Cancer Society Ohio Division.

THOMAS H. JOYCE III, M.D., Cincinnati, was elected president of the Ohio Society of Anesthesiologists. Other officers include John L. Zintsmaster, M.D., Akron, president-elect; and Nicholas G. DePiero, M.D., Garfield Heights, secretary-treasurer.

EDWARD G. MANSOUR, M.D., Cleveland, was reappointed for a second one-year term as chairman of the Professional Education Committee of the American Cancer Society, Ohio Division, Inc. Dr. Mansour is director of surgical oncology at Cleveland Metropolitan General Hospital and an associate professor in surgery at Case Western Reserve University School of Medicine.

RICHARD RETTER, M.D., Columbus, was one of seven alumni of Beloit, Wisconsin to receive a distinguished service citation. Dr. Retter is chief of neurological surgery at Mt. Carmel West Hospital and clinical instructor at Ohio State University College of Medicine.

RICHARD F. SLAGER, M.D., Columbus, was named Rotarian of the Year for 1980 by the Rotary Club of Upper Arlington. Dr. Slager is in private practice and is clinical instructor in surgery at Ohio State.

THEODORE H. WILL, M.D., Minster, was honored for 50 years in medicine and his long service to humanity. The award was presented at the Ohio Academy of Family Physicians' 30th Annual Scientific Assembly.

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**edited by
Karen S. Edwards**

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11042.

The handicapped physician

Current estimates show that four percent of all physicians are not in active practice because of a physical handicap. Of that percentage, one quarter of them are believed to have the potential to be rehabilitated into the active practice of medicine, or, in other words, 4,500 licensed physicians in this country could be returned to medical practice.

The St. Paul-Ramsey Medical Education and Research Foundation in St. Paul, Minnesota is actively involved in a project directed towards serving the needs of handicapped physicians.

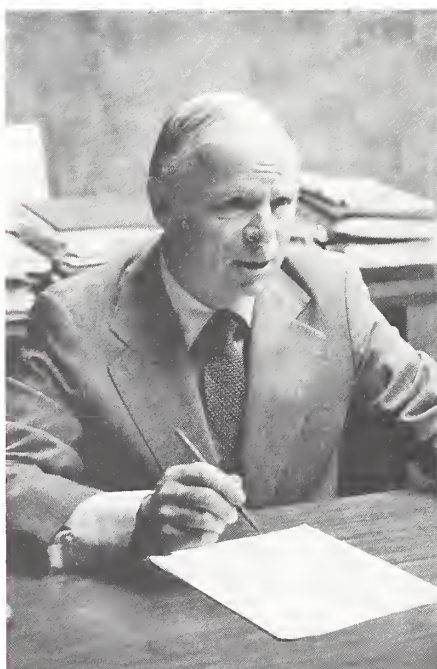
The purpose of the project is to

form a voluntary group of handicapped physicians who will provide information and referral services as well as support and advocacy for physicians who become handicapped.

Their biggest problem, however, is identifying those physicians in both the U.S. and Canada, who are handicapped.

All physicians, active or inactive, with any type of physical handicap are asked to contact F. Zondlo, M.D., St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson St., St. Paul, Minnesota 55101, for help in this project.

Improving the climate for political action committees



Hart F. Page

Hart F. Page, C.A.E., Executive Director of the OSMA, has been named to the Board of Directors of the new, nonpartisan National Association for Association Political Action Committees (NAFAPAC).

NAFAPAC has been established to improve the atmosphere in which political action committees work, and to sharpen PAC staff skills. One of the group's goals is to lobby for legislation that would be favorable to political action committees.

Joe M. Baker, Jr., acting chairman of the board of NAFAPAC says the group will make no endorsements of issues or candidates, but will simply seek to create an atmosphere in which association PACs can operate more freely, aggressively, and successfully.

MISCELLANEA

- Want to brush up your office management skills? A complete listing of AMA publications on improving medical practice management (including such topics as office design, professional corporations, and patient relations) is now available. Educational aids for medical assistants also are offered. Contact the Department of Practice Management, AMA Headquarters.

- Nuclear Medical Systems, Inc. may be marketing a birth defects test kit soon, if the Food and Drug Administration gives its approval of the company's Alpha Fetoprotein test kit. The test is designed to detect severe birth

defects such as brain and spinal cord abnormalities, by using the mother's blood instead of the amniotic fluid which surrounds the fetus. This test, the company reports, is now conducted routinely in Japan and some European countries.

- Learn in a relaxed atmosphere, urges Professional Seminars and Workshops, Inc., who have arranged to hold continuing medical education seminars and workshops aboard a luxury liner cruising the Caribbean. For more information, contact PS&W Box 66, Green Village, New Jersey 07935.

3-level membership structure cleared in Arizona

Organized dentistry's three-level membership structure does not suppress competition, a Federal District Court ruled in Phoenix, Arizona. The lawsuit, filed in 1972 by four dentists, charged that an agreement between the American Dental Association, the Arizona State Dental Association, and the Central Arizona Dental Society violated the Sherman Antitrust Act by requiring a dentist to pay dues to all three as a condition of membership in any one of the three.

The court ruled that the associations' membership rule "does not suppress competition between dentists within the state of Arizona or between dentists in Arizona and dentists in other states," and that neither the defendant associations nor their members have monopolized the practice of dentistry in Arizona.



"Hotline, 800-282-6502"

Perinatal hotline now toll-free

Advice on the care of high-risk expectant mothers and their babies is available to health professionals across the state through a toll-free hotline recently installed at Ohio State University Hospitals.

Because of its specialized staff and sophisticated equipment, University Hospitals serves as a regional referral center for patients with high-risk pregnancies.

The "perinatal hotline," provided by the hospitals since 1976, has been made toll-free through a grant from the Robert Wood Johnson Foundation, Princeton, N.J. The new toll-free number is 800-282-6502.

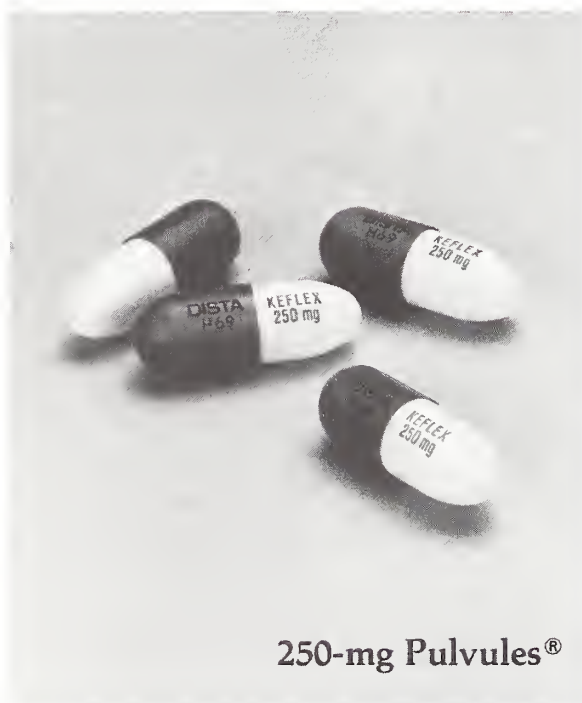
The hotline operates 24 hours a day, seven days a week, and enables physicians throughout Ohio to consult with Ohio State University Hospitals staff perinatologists.

BOOK SHELF

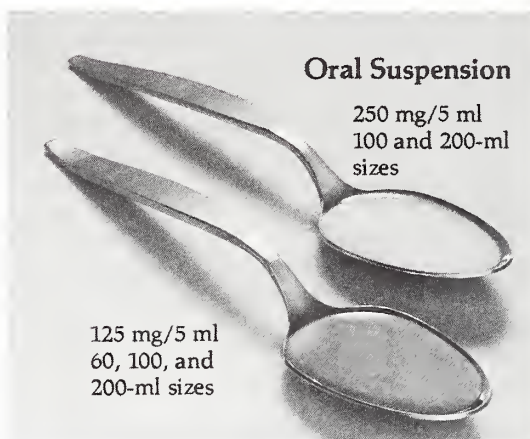
Vision Problems in the U.S. By the National Society to Prevent Blindness; \$10.00.

This 76-page factbook discusses the answers to some of the most frequently asked questions about blindness and other vision problems in this country. The prevalence of blindness, new cases of blindness, top eye hazards, and children needing eye care all are discussed. A helpful tool for those planning and evaluating programs in blindness prevention and service to the blind, the book may be ordered for \$10 a copy from the National Society to Prevent Blindness, 79 Madison Ave., New York, N.Y. 10016.

easy to take



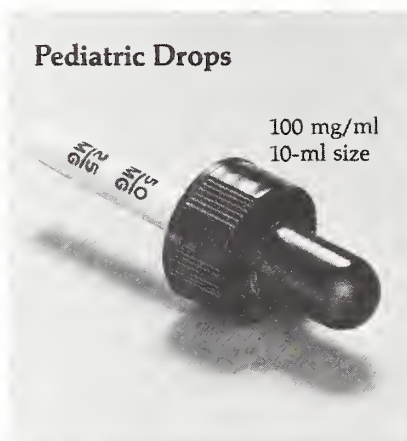
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Ohio's

Communicable Diseases:

Why aren't they being reported?

By Karen S. Edwards

Communicable disease reporting figures have always been low . . . but when these figures took yet another nosedive, the Ohio Department of Health felt it could no longer turn its back on the problem.

Few people would deny that they're out there — those communicable diseases that can spread as quickly in a community as the overlooked patch of dandelions which suddenly takes over the front yard. We **know** they're out there, and yet the statistics on communicable diseases reported in Ohio continue to hover at impossibly low figures. Why?

It's a mystery which the Ohio Department of Health (ODH), aided by a research grant from the federal

government, recently asked the Ohio State Medical Association (OSMA) to unravel.

"The figures for communicable disease reporting have always been low — not only in Ohio, but across the nation," says Frank Holtzhaur, chief of the epidemiology unit at the Ohio Department of Health.

Recently, however, these "perennially" low figures have taken yet another nose dive, and the Ohio Department of Health felt that it could

no longer turn its back on the problem.

"We had some research money left, and we decided to put it toward a project which would give us some concrete reasons as to why communicable disease reporting is not being done — or, at least, not being done adequately," Holtzhaur says, "and what we could do about it."

Previous surveys have been done by various groups and individuals on physicians' attitudes toward

The fact is, over half of the responding physicians admitted that they are not familiar with the reporting rules, and of the half who are, almost half of these find the rules confusing and unclear. Even worse, 72% do not even have a copy of the rules for reference.

communicable disease reporting.

"But not in Ohio — and nothing substantial has ever really come from any of the ones that **have** been done. They didn't tell us why the physician was not filling out the report, if he wasn't, and we didn't know what we could do, if anything, to make the reporting any easier," says Holtzhaur.

Because of the OSMA's close link to physicians, the ODH approached the Association with funds, and a plea to help out.

"We realized we needed a vehicle which would reach the physicians and ask some pertinent questions," says Robert Clinger, who is Director of the OSMA's Department of Health Education, and under whose supervision the project fell. "So we used the health department's idea of a survey."

But this survey was not going to be like any other survey that had ever been taken before.

Point-blank questions

Under the coordinating efforts of Diane Villars, a social work graduate of the University of Cincinnati (who was hired for the job by the OSMA), a series of questions was designed which asked the physician for some specific, point-blank answers as to why communicable disease reporting is so low.

"Because communicable disease reporting is required by law, we had to be very careful to stress that confidentiality would be maintained in all cases," says Villars.

Names of physicians selected to receive a questionnaire were chosen randomly from a list of OSMA members, and specific specialists were picked, as Villars and others associated with the project felt that family practitioners, internists, and pediatricians would have more contact with patients having communicable diseases than other specialists. A random selection of members of the Ohio Osteopathic Association also were chosen to receive questionnaires but they were not broken down by specialty.

"We mailed over 600 surveys," says Villars, "and 71% of them were returned either completely filled out or with enough responses to allow tabulation."

It's a surprisingly good percentage of return, and part of the credit must go to Villars who went to many local medical society meetings to urge participation.

"Physicians get so many surveys in the mail," Villars says, "and I wanted to let them know that this was an important one — a special one — to answer. I also wanted to emphasize personally the confidentiality of the responses. Some of the questions were very sensitive in nature, but we wanted honest answers. I wanted to reassure them that I would be the only one to see and tabulate their answers and that I would then throw them away."

Apparently the reassurances worked, for physicians were honest in answering the questions, Villars says, and the results from the survey revealed some very basic and concrete premises from which the ODH can build solutions.

"I think one of the major points revealed in the survey is that there is a very real communication gap between physicians and their local health departments," Villars says.

The fact is, over half of the responding physicians admitted that they are not familiar with the reporting rules, and of the half who **are**, almost half of **these** find the rules confusing and unclear. Even worse is the alarming fact that 72% of all physicians who responded do not even have a copy of the rules for reference.

Personal contact needed

"More personal contact really is needed between the local health departments and physicians," Villars says, and that, in fact, was one of the recommendations which the OSMA gave the ODH.

Monthly visits from local health department representatives were particularly stressed, and while the ODH nodded its approval, they expressed some skepticism as to whether such monthly visits would come about. However, they did take immediate action on several matters which might improve the communication gap.


"On one of the surveys, a physician

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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"I think one of the major points revealed in the survey is that there is a very real communication gap between physicians and their local health departments." — Diane J. Villars



Diane J. Villars

wrote that he would like to have a laminated card on which the reporting rules would be printed, something he could tape to his desk, or keep in another convenient location," Villars says, "and the ODH is having them printed — minus the lamination, though."

Another move which the ODH is making to alleviate some of the confusion is to combine all of the communicable diseases on one reporting card, rather than dividing them into the two Class A and Class B reporting cards, which they had been doing.

Dispensing the rules

The ODH, also on the recommendation of the OSMA, is working with the State Medical Board, using it as a vehicle through which they can dispense the reporting rules to physicians who apply for licensure and relicensure.

The survey also determined that there is currently no ongoing program which educates physicians about communicable disease reporting. Because of this, the OSMA recommended that the ODH work

with Ohio's medical schools in developing a packet of information which could be made a part of the curriculum of infectious disease courses. The ODH has made plans to do that in the future.

"The only problem we still have is with the multiple health jurisdictions," Villars says.

"It's very confusing to a physician who has patients from several health jurisdictions. He has to remember to whom to make his report. There are also many times when a physician thinks he is working in an area that has only one health jurisdiction, when in fact, there are several."

There are no ready solutions to this problem, though the OSMA has suggested either one central reporting office for each county, or direct reports to the state health department.

"Because of federal regulations and time factors, though, the OSMA's suggestion is just unfeasible right now. Maybe something will be able to be done in the future," Villars says.

"The most important thing we really wanted to come out of this survey was to stress to the physicians that communicable disease reporting is very important. One of the physician's inherent responsibilities is the

prevention of disease. Unless communicable diseases are reported, and outbreak control started, this prevention sometimes is difficult to attain," she adds.

Then why is no one reporting communicable diseases? Why, indeed. . . OSMA

Mrs. Villars wishes to thank the following people who have helped in this project:

Seth A. Young, M.S.
Ohio Department of Health
Bureau of Preventive Medicine
Research and Analysis

Frank Holtzhaur, B.S.
Ohio Department of Health
Bureau of Preventive Medicine
Chief, Epidemiology unit

Thoms J. Halpin, M.D., M.P.H.
Ohio Department of Health
Chief, Bureau of Preventive Medicine

Robert Clinger
Ohio State Medical Association
Director, Department of Health Education

ABC, NBC or CME?

*By Carol W. Mullinax
and Karen S. Edwards*

Slip into something comfortable, prop up your feet, and turn on the TV. If you're a Columbus physician, with access to Warner Amex's innovative "talk back" television cable system Qube (see "Qube-ing television's alternatives" for details on this system), you may be able to earn some Category I CME credit, without leaving the comfort of your own living room!

Last July, in an effort to increase the educational potential of their unique system, Qube obtained the rights to air an ongoing series of weekly medical lectures which have been offered to Cleveland physicians for the past six years (via personal attendance or closed circuit TV) by the Greater Cleveland Hospital Association, and the Case Western Reserve School of Medicine. The series had already been accredited by the American Medical Association (AMA) and Ohio State Medical Association (OSMA) for

Category I credit, and seemed to be an ideal subject for the type of experiment Qube had in mind.

Once an agreement had been set up with the lectures' sponsors, the Greater Cleveland Hospital Association sent out a direct mailing to Columbus physicians (the only part of the state — or the country, for that matter — where Qube is presently available), giving them a chance to participate in a new, experimental program, which would enable them to earn CME credit without leaving their front door.

For an initial registration fee of \$10 (which included a program schedule, course syllabi, and all the proper CME credit registration material) and an \$8 weekly "viewing" fee, the physician could receive the accredited lectures on his or her own home television set, in a type of "narrowcast" procedure which makes the programs available **only** to this specific group of Qube





Qube's channel selector (pictured above) allows the viewer to choose from 30 different programs, including, for an additional fee, a medical lecture series, aired from Cleveland, and accredited by the OSMA and AMA for CME Category I credit.

subscribers (sort of a target group within a target group).

The lectures have been aired since July, and to ensure that the one-hour programs fit into their viewers' heavy schedules, Qube puts them on three times a day, every day, including weekends. The lectures appear at 6 a.m., 6 p.m. and 11 p.m. — and if a viewer happens to miss a week because the subject matter is not appropriate to his specialty, or the week has been too hectic to allow an hour in front of the set — no "viewing" charge is made.

So far, the response to this unusual educational approach is impossible to judge, as information on the identity and even the number of subscribers is

kept strictly confidential.

"That's classified information," Qube officials say. "This type of telecasting is still in the experimental stages, and we can't release that kind of information yet."

Thus, there's currently no way of contacting a Qube physician-subscriber for a view (or review) of how the program is working.

Will there be some time in the future, however, when a physician who has access to the company's cable television network, be able to tune in to such a program?

Although putting the series on their regular cable network would undoubtedly mean that more physicians would be able to earn CME

credit via their televisions, it also means that anyone in 350 communities in a 38-state area would be able to tune in — and that, according to Warner Amex officials, is where the problems start.

Because of certain regulations and standards, and simply because it's also good business, a television program that is made available to a mass audience must be carefully screened for what might be construed as "offensive" material.

Self-censoring

Conceivably, the very nature of some medical topics could be construed as "offensive" to the general public, and while a suggestion has been made that either state or local medical associations screen a program prior to air time, in a kind of "self-censoring" approach, that hardly seems a satisfactory solution to the problem.

Perhaps a better answer would be to expand the number of areas where "narrowcasting" could be done, and that is precisely what the officials at Warner Amex are planning to do.

"There are several new stations on the network which will be opening soon," officials say, "and all of these will have the ability to narrowcast. If the Columbus experiment proves successful, then we'll make the televised CME programs available to these stations."

Once the market for such educational programs has proven itself and been expanded, Qube officials are quick to point out the endless opportunities that their unique "channel" can offer.

Talking back

For example, the system's interactive "talk back" buttons can be used by viewers to answer questions posed throughout or at the end of lectures, and even could be used by the lecturer or instructor as a way to check whether or not his material is being understood.

And, certainly, this convenient way of earning CME credit could be the "answer to a prayer" for older physicians or rural-area physicians who find traveling to large cities a

This convenient way of earning CME credit could be the "answer to a prayer" for older or rural-area physicians who find traveling to large cities a difficult way to earn their credit.

difficult way to earn their necessary CME credit.

If the televised CME programs are successful, Qube officials also are looking into the possibility of airing educational programs which would be aimed specifically at other groups — such as mechanics or real estate brokers.

The possibilities indeed are endless, and while such projects are only in the planning or experimental stages at this time, there's no doubt that the educational opportunities they offer sound more promising than anything the commercial television stations have given us so far.

Could it be that somewhere out there, in Marshall McLuhan's "vast wasteland," there's a television bulb that is burning a bit more brightly at last? **OSMA**

Qube-ing television's alternatives

First came commercial television, then cable, and now Qube — a third alternative in Marshall McLuhan's "vast wasteland."

Spawned in 1975 as an idea to improve Warner Cable's drooping profits, Qube came into being in 1977 — close on the heels of the company's other profit-making move, "Warner Star Channel," which offered subscribers a chance to buy a package of movies and other entertainment features for one price. "Star Channel" was outboxed by a competitive cable company's similar idea, so high hopes were pinned on Qube right from the start.

And why shouldn't they have been? Nothing like Qube had ever been done before — anywhere. It not only offered subscribers a total of 30 channels from which to select a program, but actually allowed the viewer to talk back to the TV (though most of us probably have been doing that for years).

However, Qube's two-way computer terminal made it possible for those comments to be heard — or rather seen — for the first time, as viewers, pushing a button from a row of five, were able to communicate quickly to Qube's own terminal, the answers to

certain questions posed by Qube's on-camera personnel. As if that weren't good enough, Qube's computer also knows, and shows, when a viewer has tuned out a certain program. That feature alone may be responsible for allowing the viewer to say more than he or she ever would by pushing a row of buttons!

The 30 channels Qube offers subscribers are divided into three groups of ten each. The "T" (television) column gets public access to the commercial networks, the "C" (community) column tunes in Qube's own live programming, and the "P" (premium) column has those programs, like the CME lecture series, which the subscriber must pay extra to see.

An estimated 30,000 homes in Columbus currently are receiving Qube, and plans already are made to expand the system to other cities including Cincinnati.

Right now, however, it's only available in Columbus — the city where it was born, and where it's beginning to discover some bright new alternatives to regular television fare.

— Karen S. Edwards.



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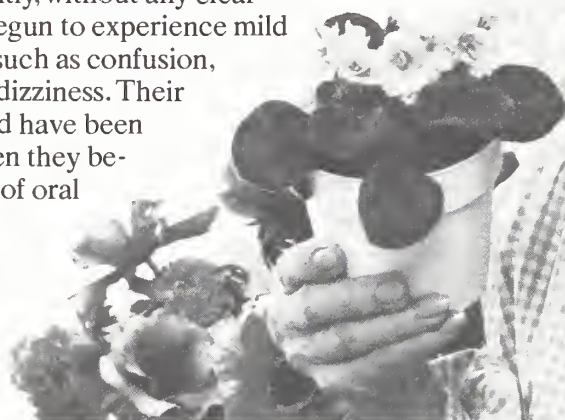
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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Hydergine sublingual tablets 1 mg, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. Hydergine sublingual tablets 0.5 mg, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.

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Final rule published in patient package inserts

The Food and Drug Administration (FDA), published its final rule regarding patient package inserts (PPI) for prescription drug products. Key provisions pertaining to prescribers include:

The physician interdict — a physician may direct (either by handwritten instruction on the prescription or orally to a pharmacist), that the dispenser withhold the PPI, unless the patient specifically requests it.

The emergency treatment exemption — a PPI need not be given to patients who receive a drug in the course of

emergency treatment (either in or out of an institutional setting.)

Health care institution options — health care institutes are required to devise a system to make PPI information available to patients on request. (Inserts need only be provided for initial dispensing, not for refills.)

For a copy of the Federal Register in which this report appears (September 12, 1980), write the Government Relations Department, the Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215.

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Mail your dues now to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA. OSMA direct bills for all dues levels on behalf of the Society.

OSMA dues are \$195. AMA membership dues are \$250. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are \$50. OMPAC-AMPAC membership is recommended.

Member-in-Training — OSMA dues are \$20. Membership entitles physician to all privileges including the right to vote and hold office.

Student Membership — a category of membership for full-time students enrolled in medical schools approved by the AMA. OSMA dues are \$15.

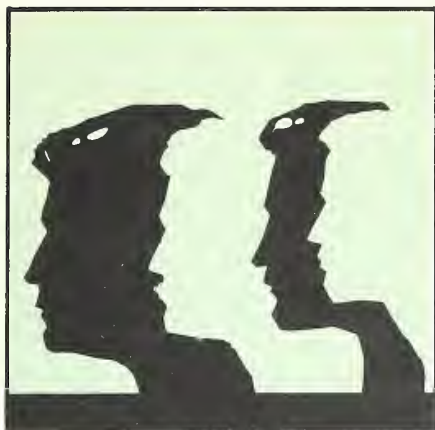
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Send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office for distribution to AMA and OMPAC.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal*, the *OSMAgram* and *Synergy*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News*.

The member who becomes eligible for exemption from dues, because of retirement or disability, should notify the Secretary-Treasurer of his/her County Medical Society. After exemption has been established, it will be renewed annually unless the status changes.

For further information on medical society membership contact:
Mrs. Katherine Wisse, OSMA Comptroller, telephone: 614/228-6971.



profiles



Leo Munick, M.D., on the road

Two Wheels on the Road

By Karen S. Edwards

If there's a bicycle at the top of the Munick family Christmas list this year, chances are it won't be any of the three Munick children who has written it down.

Leo H. Munick, M.D., a plastic and reconstructive surgeon who practices in Middletown, Ohio, has been riding bicycles "ever since I've been big enough," and is not about to give it up at the age of 49.

"Cycling gives me a chance to relax and stay in shape at the same time," Dr. Munick confides, "and it gives me a chance to really see the countryside."

Dr. Munick's cycling jaunts are not the twice-around-the-block kind that might exalt men and women of equal or even younger age. Instead, when Dr. Munick climbs onto his bicycle, he may not be seen for days.

When Dr. Munick climbs onto his bicycle, he may not be seen for days



Dr. Munick stops to take a break on one of his long-distance bicycling tours.

"I take trips on my bicycle — long trips," he adds, and rattles off the places he's been to just this year.

"I've been to Nashville, Tennessee, to visit my daughter who's attending college there, to Wheeling, West Virginia, and Cleveland," then mentions previous visits he's made to other cities from his Cincinnati-area home. "I've been to Madison, Indiana, St. Louis, Chicago, even Canada by way of Detroit."

Traveling light

Needless to say, Dr. Munick is not making his trips on your regular Schwinn bicycle with the bubble gum cards between the spokes.

"I own five bicycles, all of which are designed specifically for touring." That means that each bicycle is equipped with ten speeds and a special touring gear that makes it even easier to climb hills. Thin wheels and specially made lightweight frames make the bicycles weigh in at a featherweight total of 23 pounds each — 13 pounds lighter than most bicycle models.

Four of the bicycles he owns are Raleigh, professional touring bikes imported from England, but he also has a special one that does little more than sit in his garage.

"That bike is a Teledyne. It's made from a metal called titanium, which is not being produced anymore. In fact, the Teledyne is not being produced anymore either," Dr. Munick says.

The metal makes the bicycle extremely lightweight, but because of its present rarity, Dr. Munick is hesitant to use it on trips for fear of tempting potential bicycle thieves.

"There are lots of good touring bicycles, though. The Japanese and the French make good models, but any bicycle in the \$500-\$600 range is going to be good."

First-timer advice

If you've just purchased a bicycle and think you're now ready to take next year's tour of the Scioto River Valley (the grand bicycle tour that leaves from Columbus for Portsmouth every spring), Dr. Munick has a few words of advice.

"Start slow — have a cardiogram done first if you're out of shape. It's also a good idea to wear a helmet." (Not that Dr. Munick has had much trouble with accidents, though once he did suffer from a broken elbow when his bicycle tire caught an expansion crack in the road and he was thrown.)

And if you're a first-timer don't expect to attain the 120 miles a day at ten miles an hour that Dr. Munick presently maintains.

"In the winter, I only do 60-100 miles," Dr. Munick says — but that is **not** through Ohio's grimy snow and slush. That 60-100 miles is usually clocked up in Florida, where Dr. Munick heads every winter. "That way, I can keep on riding throughout the year, and I don't have to worry about getting back into shape."

And that's important for a man who enjoys five-star restaurants the way he does.

"Once, when I bicycled to St. Louis, I wanted to eat at one of that city's better restaurants." However, when Dr. Munick travels, he travels light — and a suit usually is not included in his bike pack.

"I didn't let that stop me though. I went out and bought a suit, had it pinned up, and went on to the restaurant," he said.

Proper cycling attire

So his bicycling is good exercise — but then so is the seven-story climb he makes up the hospital's stairs to surgery nearly every day. . .the walks he takes with his wife. . .and the times he cycles to the office or the hospital to visit patients.

"My cycling has always garnered a positive reaction from patients and nurses — even when I walk in wearing my cycling clothes."

"Cycling clothes" almost always mean a pair of shorts, "usually with a chamois sewn in to absorb perspiration," a windbreaker, and a trim of 3M Scotchguard reflector tape stitched somewhere on the outfit for those "after-dark" rides.

"I've only had a negative comment once, from a colleague who felt I wasn't suitably attired for hospital rounds. But the patients love it," he

says. . .and it's just as well, because it's unlikely that he's going to change.

He will, however, give any advice or suggestions to patients interested in cycling as a hobby.

"You don't have to be mechanically inclined to ride a bike," he tells them. "About the worst thing that's ever happened to me was a cog that broke on my back wheel. But that's rare."

He does, however, take a tool kit along on each trip . . . just in case (he admits he has had to change a few tires), and always packs a water bottle or two, which he claims is essential for touring.

"There's not much else though," he says — beyond a spirit of adventure, that is.

Dr. Munick makes his trips alone, but touring, he agrees, would be an ideal family outing.

So go ahead and locate that old Schwinn you've been hanging on to for "sentimental reasons" all these years and take a few spins around the block. You just never know where it may lead. . . **OSMA**

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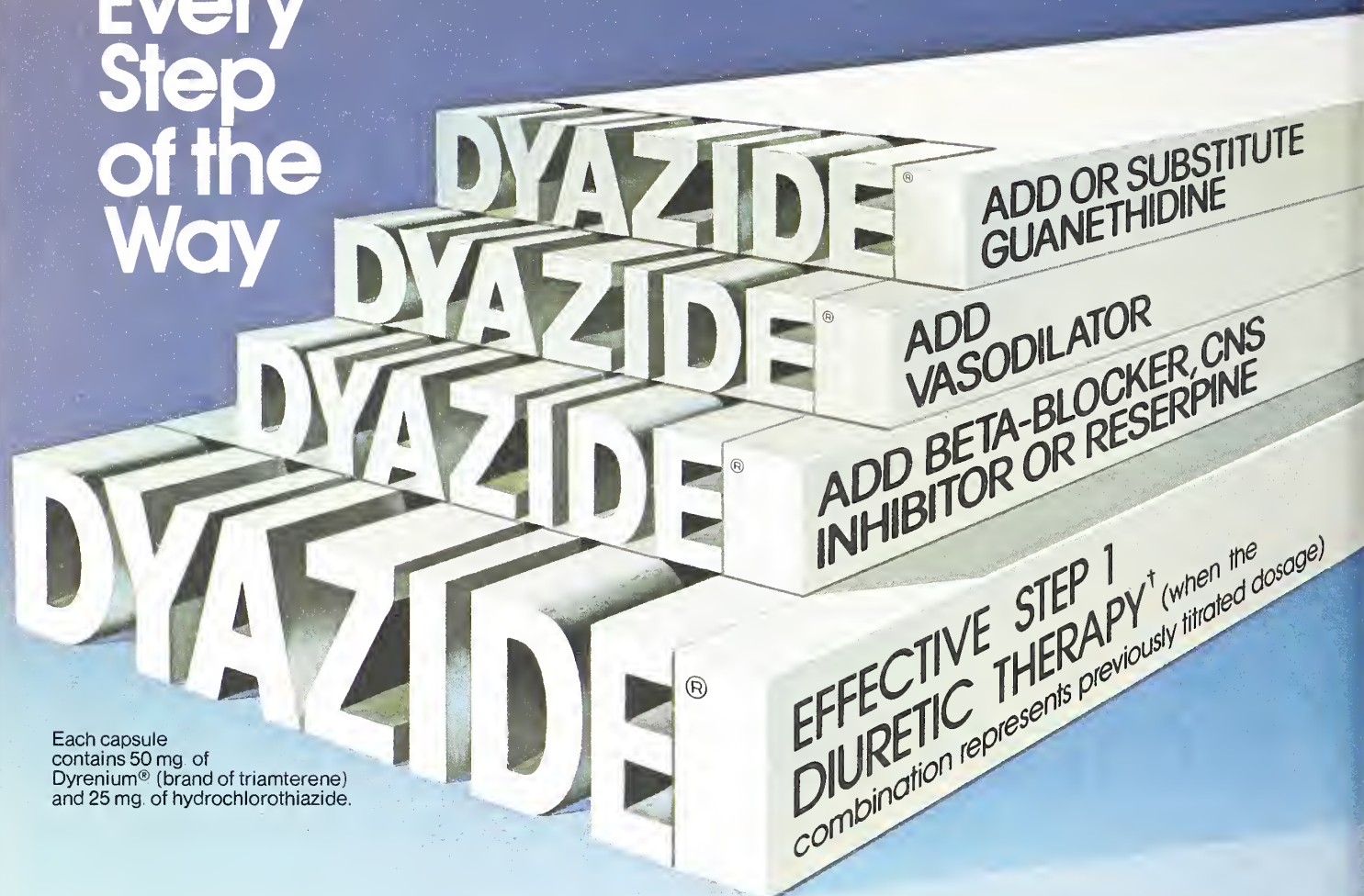


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bocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication.

possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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February

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February 13-15; The Clinic Inn, East 96th and Carnegie, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 19 credit hours; fee: \$250, \$150 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, phone: 216/444-5696.

March

CURRENT TOPICS IN BLOOD

BANKING: February 19-20; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$120, \$60 for residents; contact: Director of

POSTGRADUATE MEDICAL REFRESHER COURSE: March 2-13, 1981, Ft. Lauderdale, Florida. Credit: 50 hours, Category I; fee, \$350. Contact: Mediclinics, 1527 Edgcombe Rd., St. Paul, Minnesota 55116.

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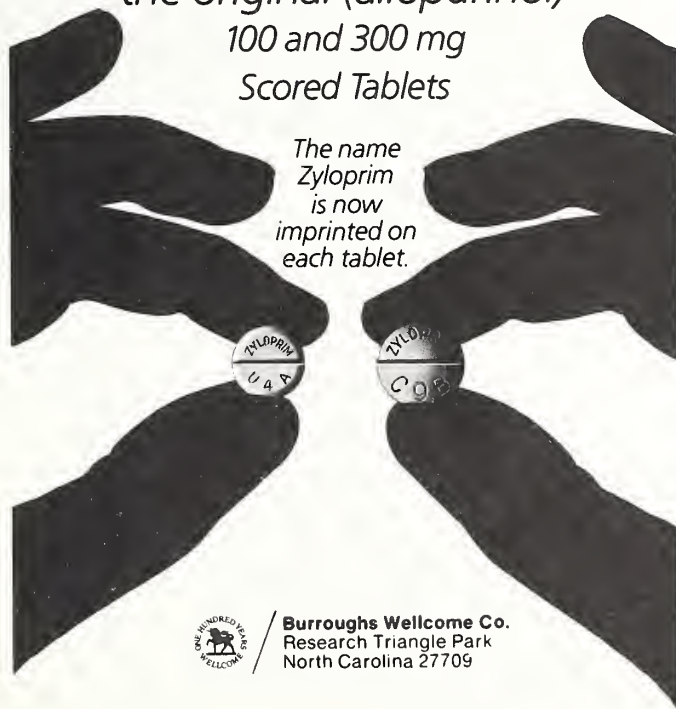
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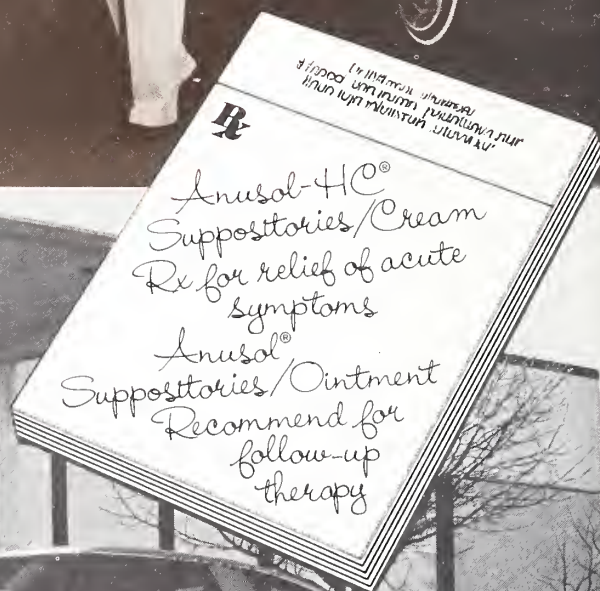
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Obituaries

CLARENCE L. HANS, M.D.,
Monroe; University of Cincinnati
College of Medicine, 1913; age 98; died
October 14; member OSMA and AMA.

ALPHONSE MARTUS, M.D.,
Chesterland; Vytauta Didziojo
University, Kaunas Lithuania, 1941;
age 76; died October 8; member
OSMA and AMA.

RAY RUEL MOSELY, M.D.,
Atwater; University of Oklahoma
Medical School, 1918; age 86; died
March, 1979; member OSMA and
AMA.

SHIRISH R. PANDYA, M.D.,
Orville; B.J. Medical College, Gujarat
University Ahmedabad, Gujarat, India,
1960; age 45; died October 10; member
OSMA and AMA.

SANDOR A. SCHWARTZ, M.D.,
Cleveland; University di Roma, Rome,
Italy, 1929; age 76; died October 8;
member OSMA and AMA.

RALPH HUGHES CURNAYN,
M.D., Cincinnati; Eclectic Medical
College, Cincinnati, 1929; age 76; died
October 14; member OSMA and AMA.

THEODORE J. DODD, M.D.,
Canton; Ohio State University College
of Medicine, 1942; age 64; died
September 7; member OSMA and
AMA.

Next Month in the *Journal*

- "Workers' Compensation" — the second article in a series explaining the Third-Party Payers system will take a look at Workers' Compensation, and how it works.
- "The 1981 Annual Meeting" — registration forms and meeting dates will be included to give you an early start on your plans. Also look for the Journal's Photographic Contest entry form.

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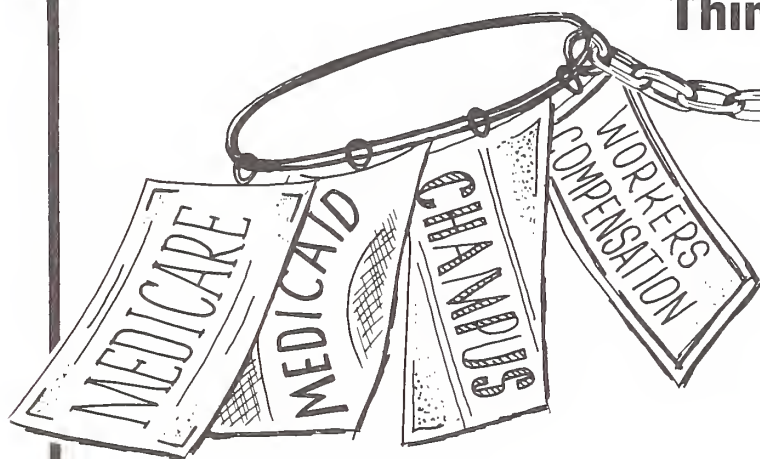
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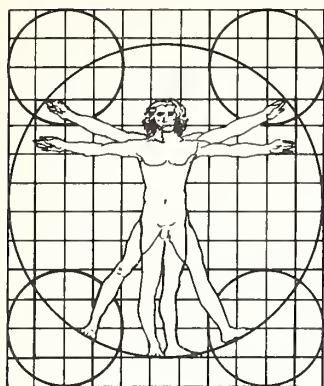
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CLINICAL & SCIENTIFIC

OUTPATIENT PEDIATRIC SURGERY: THE CONSUMER'S VIEW

Paul M. Glen, M.D.
M. El-Shafie, M.D.
Charles Klippel, M.D.

Outpatient surgery is an effective method of health care in infants and children. We believe the community receiving this type of health care should be the final judge of its effectiveness and quality. Questionnaires concerning this were sent to the parents of children who were operated on as outpatients. The results of this study revealed an overwhelming acceptance of this method. Several suggestions were made by the parents and these will be taken into consideration in improving the quality of pediatric outpatient services.

OUTPATIENT SURGERY has been shown to be an effective method of health care delivery in the pediatric age group.¹⁻⁴ The medical, psychological, and economic benefits of outpatient surgery have been studied,⁵⁻¹⁰ however, there has not been sufficient investigation into the public's opinion. It is our belief that the community receiving the health care should be the final judge concerning acceptance of the method.

The purpose of this study was to explore the "consumer" viewpoint through the reactions of the parents of children who underwent outpatient surgery. Our goal was to utilize the parents' evaluations and comments to improve the outpatient surgery services. The results of the study have allowed us to assess the quality of our patient care and instigated the implementation of several refinements in our procedures.

Method

During the last two years, over 450 pediatric outpatient surgical procedures were performed at the Medical College of Ohio and associated hospitals. Questionnaires were mailed to the parents of the children undergoing surgery, to be returned anonymously in order to encourage criticism.

There were 24 questions asked concerning (1) understanding of preoperative instructions; (2) understanding of the procedure to be performed; (3) feelings about the setup of the outpatient surgery area; (4) understanding of postoperative in-

structions; (5) comfort and preparedness in taking the child home; (6) postoperative complications and pain medication; (7) the child's feelings concerning the experience; and (8) solicited comments concerning outpatient surgery. The parents also were asked specifically if they would submit to an outpatient surgical experience again.

Results

Two hundred twenty parents returned completed questionnaires, a 51% return from a total of 431 questionnaires. The ages of the children undergoing outpatient surgery ranged from 3 weeks to 17 years, a mean of nearly 4 years of age and a median of approximately 3 years of age. There were 170 males and 50 females. Herniorrhaphies comprised the overwhelming majority of procedures, which are listed in the table.

Preoperative instructions were understood by 99.5% (215/219) of the parents and were followed without difficulty by 97% (206/213). The parents felt that they had a good comprehension of the procedure to be performed for their child, 98% (215/219) responding affirmatively. Parents for the most part were comfortable during the operative procedure, 92% (200/218) feeling adequately informed about their child's condition.

Dr. Glen, formerly medical student at Medical College of Ohio, Toledo, is currently a Resident, Department of Surgery, University of Cincinnati.

Dr. El-Shafie, Toledo, Assistant Professor, Medical College of Ohio.
Dr. Klippel, Toledo, Associate Professor in Pediatric Surgery, Medical College of Ohio.

Presented at the 26th International Meeting of the British Association of Pediatric Surgeons in Marseille, France, in July 1979.

Reprint requests to Medical College of Ohio, Department of Surgery, C.S. 10008, Toledo, Ohio 43699 (Dr. El-Shafie).

Submitted December 6, 1979.

Postoperatively, the parents generally understood the explanations given by the surgeon and nurses, with greater than 77% having a definite, very clear comprehension, and less than 1% claiming a complete lack of clarity, the remainder of the responses falling between the two extremes. Most parents felt very comfortable in having their child leave the hospital upon discharge, the distribution shown in the figure, and 93% (198/213) felt adequately instructed in what to look for in postoperative complications.

Postoperative symptoms, as the parents viewed them, occurred in 65% (143/220) of the patients. The parents noted crying with pain in 34% of the cases. Our survey revealed that 31% (66/216) of the patients received pain medication postoperatively from their parents and usually consisted of a mild analgesic. The medications included acetyl salicylic acid (19% of the total study population), acetaminophen (8%), propoxyphene (1%), and unknown drugs (3%).

There was swelling or bruising around the wound which required treatment in an emergency room. The incidence of nausea was 17% and vomiting 14%, both occurring mainly within the first several hours after discharge. After four hours from discharge, the occurrence of vomiting fell to 5%, and only one patient out of 220 (0.5%) had vomiting after the first 24 hours. One child (0.5%) had breathing difficulty which cleared up within the first four hours.

Postoperative symptoms caused six parents to take their child to see a physician and led four others to telephone a physician, making a total of less than 6% of the parents in the study who sought the services of a physician postoperatively. Only one child out of over 220 operations had to be admitted to a hospital after surgery, for an unspecified reason.

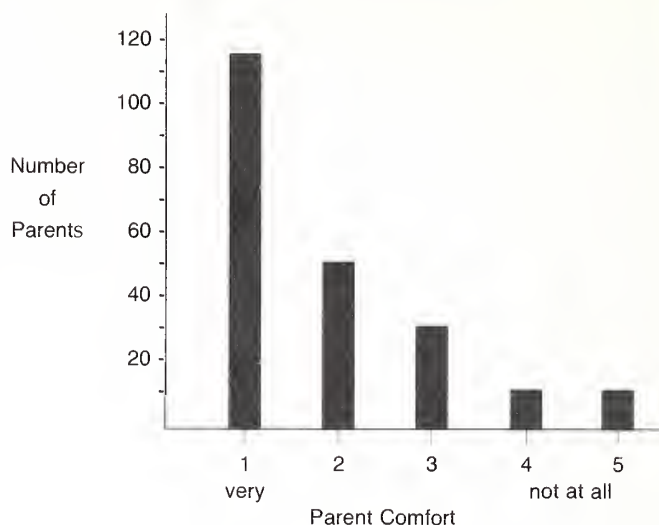
We found that 87% (182/210) of the parents would not have preferred hospitalization of their child for the operation. In addition, responding to the key question: "If you were presented with an occasion to have an operation performed on one of your children as an outpatient, would you go through the experience again?", 94% (201/216) of the parents replied affirmatively.

Among the 12 parents (6% of the total study population) who would prefer not to go through outpatient surgery again, six mentioned feelings of helplessness and apprehension over the adequacy of their care at home. Three parents felt overwhelmed due to other children at home who also needed care. One parent lived 40 miles away from the nearest hospital and, after feeling it necessary to have the child seen in an emergency room, would be afraid to try the outpatient route again. Two parents claimed that lack of full insurance coverage for outpatient surgery was the only reason for their not wanting to have another outpatient surgical procedure.

Discussion

Pediatric outpatient surgery has been shown to have several advantages. These include a decreased incidence of hospital-acquired infections,^{4,6,7} a reduction of family unit disruption, and decreased separation anxiety,⁷ an increased availability of

Parent Comfort Leaving Hospital



hospital beds for other admissions, and a means of lowering the cost of health care.^{5,8,11}

This study has shown that pediatric outpatient surgery is well accepted by the public. However, we discovered that there are some problems with our procedures. The complaints and suggestions elicited by our survey will serve as guidelines for correcting these problems.

In spite of our careful efforts, not all the parents expressed a complete understanding of instructions and explanations. Physician-parent communication is important not only in preparing the parents for their role in the delivery of health care to their child, but also in serving to alleviate parent and child anxieties. The results of our study can provide valuable aid for discussions with the parents and their children.

To further allay parental anxieties, one of the hospitals in our study has implemented a procedure of telephoning the parents during the evening following the surgery to provide reassurance. This is a policy that is well appreciated by the parents.

A suggestion by several parents was that they be allowed to be in the recovery room after their child had awakened from anesthesia. This would serve to alleviate much of the child's fears. Having the parents in the recovery room has been shown to be effective after being initiated at one of the hospitals in our study. If there happens to be a combined inpatient and outpatient recovery room, a separate area can be easily constructed to allow this.

Some of the parents mentioned that they felt uncomfortable having a long wait before their child's surgery. One patient's fears can be spread readily among the others in the waiting room. At one of our hospitals, the anesthesiology department has insisted upon having the child under preoperative observation for a few hours, attempting to lessen the incidence of emesis while under anesthesia and possible aspiration. We are opposed to this policy because of the anxiety problems it can create and believe that adequate emphasis to the parent concerning nothing orally before the operation is sufficient.

Several parents had complaints about talking with the surgeon in a crowded, noisy waiting room and suggested a more private conference area for discussions. Because the postoperative instructions are very important to the effectiveness of outpatient surgery, such an area should be allotted.

Another complaint was that outpatients occasionally had difficulty in learning the pathology report on biopsy specimens. The physicians involved should be aware of this and make special attempts to insure that the parents know the results.

Pediatric Outpatient Operations

	Number	Percent
Herniorrhaphy	169	77%
Orchiopexy	17	8%
Hydrocelectomy	16	7%
Cyst excision	9	4%
Node excision	8	4%
Thyroglossal duct cyst excision	4	2%
Circumcision	2	1%
Mole excision	2	1%
Others	7	

A practical suggestion mentioned by several parents was that they should have been advised to bring pajamas for their children to wear postoperatively. We believe this is an important instruction for the parents, especially with procedures requiring an incision near the beltline.

Because we occasionally forget to discuss some details, we think it may be worthwhile to have a set of printed instructions to give to the parents before surgery. A wellwritten, easy-to-read instruction sheet can assist the understanding of preoperative explanations and help to alleviate parental anxieties.

The parents who preferred not to have outpatient surgery for their children had several reasons. Among them was the lack of full insurance coverage. Several years ago, there was a reluctance among the health insurers to cover totally outpatient surgery expenses, but most of the companies now have realized the cost savings with outpatient procedures. However, a few insurance companies still have refused to comply. We plan to write to all the health insurance companies to explain the benefits of outpatient surgery to the patient, the insurance companies, and to the country.

The most often-cited reason for not wanting outpatient surgery was a feeling of complete helplessness in care of the child postoperatively. Other parents mentioned that with other children to take care of at home, they did not feel able to devote adequate attention to the recuperating child. Not every parent is able to handle the responsibility of the child's postoperative home management. In these cases, the surgeon may wish to opt for inpatient care of the child. Patients who live an uncomfortably long distance from an adequate hospital also may necessitate a hospital admission for a surgical procedure which normally could be handled on an outpatient basis.

Overall, the great majority of parents are willing and able to have outpatient surgery for their children when feasible. Several parents commented that they had gone through both inpatient and outpatient surgery with their children and much preferred outpatient surgery whenever possible, claiming that it is much less frightening to the child and stating that outpatient surgery is a great deal easier on the parents as well.

Summary


Pediatric outpatient surgery has been shown to be medically well based, psychologically beneficial, and effective in reducing the cost of health care. We believe that the parents and children undergoing outpatient surgery should be the final judges concerning our methods.

Our study has shown that the "consumers" are overwhelmingly in favor of outpatient surgery for their children. Careful consideration of the complaints and suggestions mentioned by parents and children can further enhance the effectiveness of pediatric outpatient surgery.

Acknowledgments: The personnel in the Outpatient Surgery Department, especially Cindy Zatrock, R.N., who helped in preparing the questionnaire and tabulating the results.

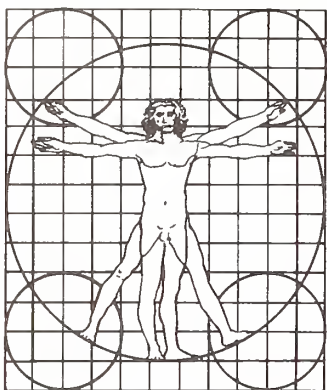
References

1. Nicoll JH: The surgery of infancy. *Br Med J* 2(2542):753-754, 1909.
2. Herzfeld G: Hernia in infancy. *Am J Surg New Series* 39(2):422-428, 1938.
3. Lawrie R: Operating on children as day-cases. *Lancet* 2:1289-1291, 1964.
4. Othersen HB Jr: Outpatient herniorrhaphy for infants. *Am J Dis Child* 116:78-80, 1968.
5. Cloud DT, Reed W, Ford JL, et al: The surgicenter: A fresh concept in outpatient pediatric surgery. *J Pediatr Surg* 7:206-212, 1972.
6. Morse TS: Pediatric outpatient surgery. *J Pediatr Surg* 7:283-286, 1972.
7. Steward DJ: Experiences with an outpatient anesthesia service for children. *Anesth Analg (Cleve)* 52:877-880, 1973.
8. Saltystein EC, Sullivan CB: Outpatient surgery. *Wis Med J* 74:57, 1975.
9. Steward DJ: Outpatient pediatric anesthesia. *Anesthesiology* 43(2):268-276, 1975.
10. El-Shafie M, Shapiro RP: Outpatient pediatric surgery in a developing country. *Pediatrics* 60(4, pt 2): 600-602, 1977.
11. Saltystein EC, Sullivan CB, Patterson EM, et al: Ambulatory surgical unit. *Arch Surg* 108(2):143-146, 1974.



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CLINICAL & SCIENTIFIC

OSTEOPOROSIS: ITS MORBIDITY AND PREVENTION

Thomas G. Skillman, M.D.

Approximately 20% of American Women will suffer a hip or vertebral fracture because osteoporotic changes have diminished the strength of their bones. Long-term metabolic studies show that women have a significant loss of bone mass during the perimenopausal years. It is logical to select women who are at greatest risk of osteoporosis and treat them with estrogen and calcium supplements from the menopause through the sixth decade of life. Hopefully, the risk of fracture could be reduced.

OSTEOPOROSIS IS A MAJOR health problem in the United States. One in three postmenopausal American women have osteoporosis and one in five will suffer a hip or vertebral crush fracture. The diagnosis of osteoporosis usually is delayed until fracture occurs. By then the average skeleton has been depleted of 40% of its normal 1,000 grams of calcium.

Nature of Osteoporosis

In pure osteoporosis the bone cells, bone matrix, and crystals are normal as well as the serum concentrations of calcium phosphorus and alkaline phosphatase. The external dimensions of the bones also are normal so that bone volume does not change. The major aberration is reduction in the thickness of the tubular walls of cortical bone and reduced size of the trabeculae of cancellous bone. These changes are described as decreased bone mass without decrease in bone volume. The smaller mass reduces bone strength and permits fracture.

Clinical Manifestations

The classic osteoporotic is a white woman, over 50 years of age, who has a small skeleton. There is often a family history of osteoporosis. The usual event which brings the patient to

the physician is a fracture and there are three classic fractures. The most common are anterior wedge compression fractures of the lower thoracic and upper lumbar vertebrae, resulting in low back pain, accentuated by flexion. Next is Colle's fracture of the forearm, and last is hip fracture. However, mortality associated with the latter is about 17%.

Physical finding may be sparse. Height may be reduced by 1 to 6 inches if multiple vertebral fractures have occurred. A Dowager's hump is common. Some patients develop flank pain caused by telescoping of the lower ribs into the pelvic brim. Pain is secondary to compression of costal cartilage. Rib fractures not related to definable trauma are common. Curiously, there may be no symptoms in patients with multiple vertebral fractures.

Pathogenesis

The etiology of osteoporosis probably is multifactorial. Genetic predisposition, accelerated age-related bone atrophy, estrogen loss at the menopause, decreased vitamin D, decreased intestinal calcium absorption, and hypercalciuria each or all may play a major or minor role. The most clearly defined factor is estrogen loss at the menopause.

Recently, Heaney, et al¹⁻² showed that women who took estrogen during their perimenopausal years were protected from calcium loss associated with decreased intestinal absorption and increased urine loss (see table). They determined that just

Calcium balance studies in women before the menopause and untreated and estrogen treated after menopause:

Group (Number)	Mean Age	Average Calcium Turnover Mg. per Day				
		Intake	Absorbed	Urine	Stool	Balance
Premenopause (207)	42.3	646	202	120	102	-20
Post-Meno. Untreated (41)	45.6	659	190	132	101	-43
Post-Meno. Treated (26)	47.4	630	201	114	94	-7

Abstracted from Heaney, Recker, Saville: 1978

Dr. Skillman, Columbus, Professor of Endocrinology, The Ohio State University College of Medicine.
Submitted February 20, 1980.

prior to the menopause, women are already in a state of modest calcium loss. Calcium balance studies of estrogen-treated and nonestrogen-treated women showed that perimenopausal calcium loss was prevented by estrogen. Decreased intake of calcium also is important.

The study of Riggs, et al³ showed that feeding calcium to osteoporotic women reduced bone resorbing activity assessed by bone biopsy.

Increased parathyroid hormone (PTH) may play a role in pathogenesis. Wiske, et al⁴ demonstrated that PTH increases with advancing age and is associated with significant decreases in serum ionized calcium and inorganic phosphate.

It also has been speculated that advancing age may be associated with impairment of hepatic hydroxylation of vitamin D. This could result in reduced 1,25-dihydroxy vitamin D and cause reduced intestinal calcium absorption.

Diagnosis

The most important factor in managing osteoporosis is early diagnosis. If the disorder is to be diagnosed prior to the time in life when there is increased risk of fracture, special radiologic or densitometric technology should be employed. A carefully made x-ray film of the hand permits rough estimation of thickness of the cortices of tubular bones. Osteoporosis is present if the ratio of cortical area to total area (see figure) is less than 0.7.

It should be appreciated that this method does not account for cystic resorption. A better method is measurement of cortical and trabecular bone density using photon absorption.⁵ In simplified terms, photons from radioiodine-125 are directed through trabecular and compact bone of the radius. The degree of penetration, as measured by a gamma detector placed on the other side of the bone, is inversely proportional calcium content. A particular virtue of this method is precision in sequential measurement, which permits detection of decreased bone mass prior to development of symptoms or diagnosability by x-ray film.

Differential diagnosis may be challenging because many osteoporotics have associated osteomalacia. Bone biopsy may be necessary if both diseases exist. Less formidable differential diagnoses include hyperparathyroidism, multiple myeloma, carcinomatosis, intestinal malabsorption, and osteoporosis, secondary to covert long-term hyperthyroidism.

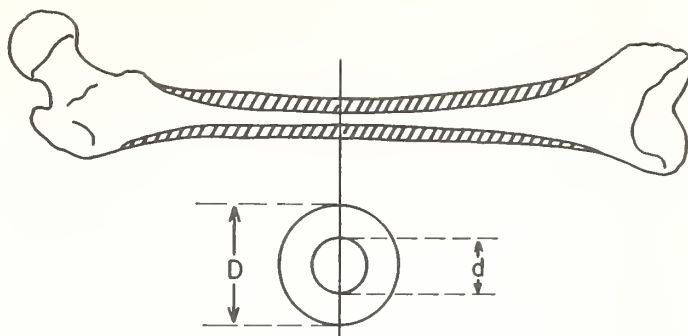
Treatment

There is presently a better understanding of pathogenesis of osteoporosis, therefore, various methods to prevent and treat it have achieved respectability.

Estrogens. — In 1940 Albright⁶ asserted that osteoporosis was causally related to decreased estrogen secretion relative to the menopause. The work of Heaney and Recker^{1,2} strengthens the Albright hypothesis. It now is appreciated that estrogen effects are anticatabolic rather than anabolic as Albright proposed, however, the mode of action is less important than the result.

Large daily doses of estrogen may be associated with increased risk of hypertension, stroke, myocardial infarction, and hypertriglyceridemia. Long-term estrogen increases the risk of endometrial carcinoma. Nevertheless, most physicians treat early postmenopausal women with estrogen and carefully monitor them for side effects. Usually a low dose of conjugated estrogens such as 3.0 to 0.625 mg for 25 days a month is sufficient to prevent negative calcium balance.

If a given patient has not had a hysterectomy, a five-day course of 10 mg of medhydroxy progesterone may be given, anticipating that estrogen-stimulated endometrial cells will be sloughed with the menses. Patients who have irregular menstrual bleeding require uterine curettage.



$$\text{RATIO} = \frac{\left(\frac{D\pi}{2}\right)^2 - \left(\frac{d\pi}{2}\right)^2}{\left(\frac{D\pi}{2}\right)^2} = 70\% = \text{NORMAL}$$

Estimation of Effective Bone Mass The Ratio of Cortical to Total Cross Sectional Area

Oral Calcium. — Most subjects with osteoporosis relate histories which suggest that they have had a life-long, low-calcium intake. Since 40% to 60% of their total body calcium has been depleted at the time of diagnosis, it is wise to add calcium supplements to food.

Heaney² estimates that an intake of 1.73 or more grams of elemental calcium per day may restore calcium balance. A quart of skimmed milk will furnish 1.2 grams. Calcium carbonate, 3 grams per day, also provides 1,200 mg.^{7,8}

Vitamin D. — This substance stimulates production of a calcium-binding protein by intestinal cells and improves calcium absorption. It has been recommended that a 50,000-unit capsule of vitamin D be used once a week. It is mandatory that patients who might abuse medication have their serum calcium monitored if vitamin D is given.

Fluoride. — The use of fluoride to treat osteoporosis is controversial.^{9,10} Small amounts of fluoride taken over long periods of time seem to protect against osteoporosis. Large doses result in development of fragile bones. This author has encountered no problems using 50 mg of fluoride ion per day for up to 25 weeks. Nevertheless, there is no proof that fluoride treatment has efficacy in osteoporosis.

References

1. Heaney RP, Recker RR, Saville PD: Menopausal changes in bone remodeling. *J Lab Clin Med* 1978;92(6):964-970.
2. Heaney RP, Recker RR, Saville PD: Menopausal changes in calcium balance performance. *J Lab Clin Med* 1978; 92(6):953-963.
3. Riggs BL, Jowsey J, Kelley PJ, et al: Effects of oral therapy with calcium and vitamin D in primary osteoporosis. *J Clin Endocrinol Metab* 1976;42(6):1139-1144.
4. Wiske PS, Epstein S, Bell NH, et al: Increases in immunoreactive parathyroid hormone with age. *N Engl J Med* 1979;300(25):1419-1421.
5. Smith DM, Khairi MRA, Johnson CC Jr.: The loss of bone mineral with aging and its relationship to risk of fracture. *J Clin Invest* 1975;56(2):311-318.
6. Albright F, Bloomberg E, Smith PH: Post-Menopausal Osteoporosis. *Trans Assoc Am Physicians* 1940;55: 298-305.
7. Recker RR, Saville PD, Heaney RP: The effect of estrogens and calcium carbonate on bone loss in postmenopausal women. *Ann Intern Med* 1977;87(6):649-655.
8. Horsman A, Gallagher JC, Simpson, M, et al: Prospective trial of estrogen and calcium in postmenopausal women. *Br Med J* 1977;2(6090):789-792.
9. Lukert BP, Bollinger RE, Meek JC: Acute effect of fluoride on 45-calcium dynamics in osteoporosis. *J Clin Endocrinol Metab* 1967;27:828-835.
10. Bernstein DS, Cohen P: Use of sodium fluoride in the treatment of osteoporosis. *J Clin Endocrinol Metab* 1967;27:197-210.

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Office Space

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NEW MEDICAL BUILDING - COLUMBUS - SAWMILL AREA. Three suites are available for occupancy by early 1981. Contact C. J. Kelley, D.D.S. evenings/weekends 614/846-6699.

Practice For Sale

FAMILY PRACTICE FOR SALE IN OHIO DUE TO RETIREMENT, with established family practice large enough to accommodate two physicians; located in scenic SE Ohio rural area near I-70/I-77. Fully-equipped seven-room office w/physiotherapy and x-ray; attached ten-room, brick colonial house, in-ground pool, two-car garage, basement. Gross income 6 digits. Staff privileges in nearby modern hospital and loan guaranteed; will stay to introduce if requested. Down payment negotiable. Good area schools. M.W. Hnatiuk, M.D., 24 Mill St., Senecaville, OH 43780. Phone (614) 685-6049 after 6:00 P.M.

INTERNAL MEDICINE, SOLO PRACTICE/OFFICE FOR SALE: in Cincinnati, Ohio. Carew Tower downtown area. Gross \$140,000. Established growing practice fully equipped with complete x-ray and lab. Will stay and introduce. Terms and starting date negotiable. Must sell, my family relocating. Reply to Box No. 904, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Librium® 5mg, 10mg, 25mg capsules chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral-Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products, Inc.
Manati Puerto Rico 00701

NOT TO CIRCULATE

